
State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Filing at a Glance

Company:	Pan-American Life Insurance Company
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
State:	Arkansas
TOI:	H04 Health - Blanket Accident/Sickness
Sub-TOI:	H04.000 Health - Blanket Accident/Sickness
Filing Type:	Form
Date Submitted:	09/17/2012
SERFF Tr Num:	ICCI-128674182
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	B-OCCACC-TA (6/12)
Implementation	On Approval
Date Requested:	
Author(s):	Brenda Dawson
Reviewer(s):	Donna Lambert (primary)
Disposition Date:	11/01/2012
Disposition Status:	Approved
Implementation Date:	
State Filing Description:	

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

General Information

Project Name: Pan-Am Blanket Group Occupational Accident Only Policy Status of Filing in Domicile:
Only Policy
Project Number: B-OCCACC-TA (6/12) Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Employer, Association, Blanket Overall Rate Impact:
Filing Status Changed: 11/01/2012
State Status Changed: 11/01/2012 Deemer Date:
Created By: Brenda Dawson Submitted By: Brenda Dawson
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

We are hereby submitting the above referenced forms for filing in your state. These forms are new and are not intended to replace any forms previously approved in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Pan-American Life Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc.

Blanket Group Occupational Accident Only Policy form B-OCCACC-TA-P (6/12) will be issued as blanket insurance in your state. Blanket Group Application form will be completed by the group to apply for the Policy. The Group Policy was issued to an Association group located outside your state. The group policy was issued to the Professional Association of Independent Contractors (PAIC) association. Attached is the required Arkansas checklist, bylaws and articles of incorporation.

Form B-OCCACC-TA-C (6/12) is the Blanket Group Certificate evidencing coverage under the Group Policy. Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) will be attached to all Certificates issued in Arkansas.

This is a group occupational accident only policy providing coverage for subscribers for occupational-related injuries only. Benefits include among others, accidental death & dismemberment benefits, accidental disability benefits, and accident medical expense benefits.

The following riders are also used with this plan:

Aggregate Limit Rider – B-OCCACC-TA-R-AL (6/12)
Special Rider #1 – B-OCCACC-TA-R-AMED (6/12)
Special Rider #1 – B-OCCACC-TA-R-CAN (6/12)
Casual Laborer – B-OCCACC-TA-R-CL1 (6/12)
Covered Activity Rider – Casual Laborer – B-OCCACC-TA-R-CL2 (6/12)
Contingent Liability Coverage Rider – B-OCCACC-TA-R-CL (6/12)
Covered Activity Rider – Courier Operation – B-OCCACC-TA-R-CO (6/12)
Covered Activity Rider – Limousine Operation – B-OCCACC-TA-R-LIM (6/12)

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Non-Occupational Benefit Rider – B-OCCACC-TA-R-NON (6/12)
Special Rider #1 – B-OCCACC-TA-R-PAS (6/12)
Pre-Existing Condition Rider – B-OCCACC-TA-R-PE (6/12)
Covered Activity Rider – Trucking Operation – B-OCCACC-TA-R-TROP (6/12)

Bracketed material is considered variable data.

The Policy documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract other than listed or bracketed variables, or to the general print size.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com
3925 East State Street, Suite 200 815-316-6714 [Phone]
Rockford, IL 61108 815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Pan-American Life Insurance Company	CoCode: 67539	State of Domicile: Louisiana
1300 Godward Street NE	Group Code: 525	Company Type:
Suite 6800	Group Name:	State ID Number:
Minneapolis, MN 55413	FEIN Number: 72-0281240	
(612) 331-0112 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$750.00
Retaliatory?	No
Fee Explanation:	\$50 per form
Per Company:	No

Company	Amount	Date Processed	Transaction #
Pan-American Life Insurance Company	\$750.00	09/17/2012	62729885

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/01/2012	11/01/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	11/01/2012	11/01/2012
Pending Industry Response	Donna Lambert	10/30/2012	10/30/2012
Pending Industry Response	Donna Lambert	10/09/2012	10/09/2012
Pending Industry Response	Donna Lambert	10/01/2012	10/01/2012

Response Letters

Responded By	Created On	Date Submitted
Brenda Dawson	11/01/2012	11/01/2012
Brenda Dawson	10/31/2012	10/31/2012
Brenda Dawson	10/30/2012	10/30/2012
Brenda Dawson	10/01/2012	10/01/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Amendatory Endorsement	Brenda Dawson	10/30/2012	10/30/2012
Form	Group Certificate	Brenda Dawson	09/18/2012	09/18/2012

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Disposition

Disposition Date: 11/01/2012

Implementation Date:

Status: Approved

HHS Status: Not Reported

State Review:

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Authorization Letter	Approved	Yes
Supporting Document (revised)	Statement of Variability	Approved	Yes
Supporting Document	Statement of Variability	Replaced	Yes
Supporting Document	Professional Association of Independent Contractors (PAIC) bylaws and articles of incorporation, cklist	Approved	Yes
Form (revised)	Group Certificate	Approved	Yes
Form	Aggregate Limit Rider	Approved	Yes
Form (revised)	Special Rider #1	Approved	Yes
Form	Special Rider #1	Replaced	Yes
Form	Special Rider #1	Approved	Yes
Form	Casual Laborer Rider	Approved	Yes
Form	Covered Activity Rider - Casual Laborer	Approved	Yes

SERFF Tracking #:

ICCI-128674182

State Tracking #:

Company Tracking #:

B-OCCACC-TA (6/12)

State:

Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name:

Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number:

Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Contingent Liability Coverage Rider	Approved	Yes
Form	Covered Activity Rider - Courier Operation	Approved	Yes
Form	Covered Activity Rider - Limousine Operation	Approved	Yes
Form	Non Occupational Benefit Rider	Approved	Yes
Form	Special Rider #1	Approved	Yes
Form	Pre-Existing Condition Rider	Approved	Yes
Form	Covered Activity Rider - Trucking Operation	Approved	Yes
Form	Application	Approved	Yes
Form (revised)	Amendatory Endorsement	Approved	Yes
Form	Amendatory Endorsement	Replaced	Yes
Form	Amendatory Endorsement	Replaced	Yes
Form	Amendatory Endorsement	Replaced	Yes
Form	Amendatory Endorsement	Replaced	Yes
Form	Group Certificate	Replaced	Yes
Form	Group Policy	Approved	Yes

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/01/2012
Submitted Date	11/01/2012
Respond By Date	12/03/2012

Dear Brenda Dawson,

Introduction:

Objection 1

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Please add the required information to accompany policies as stated in ACA 23-79-138 and Bulletin 15-2009 to the certificate. If this information has been previously approved by amendment, please give the SERFF Tracking # and approval date of that amendment. I look forward to approving this submission when this small revision is made. Thank you for your cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/30/2012
Submitted Date	10/30/2012
Respond By Date	11/30/2012

Dear Brenda Dawson,

Introduction:

Objection 1

- Group Policy, B-OCCACC-TA-P (6/12) (Form)

Comments: Please revise the Premium Changes provision to limit premium changes to once in a twelve-month period.

Objection 2

- Amendatory Endorsement, B-OCCACC-TA-AE-AR (6/12) (Form)

Comments: Please add something in reference to the misstatement being fraudulent or material. Please consider something similar to the capitalized wording.

(c) Misstatement of Eligibility. We reserve the right to refund any premiums reported and paid to Us on any insured person who is found to not meet the Certificate definitions of a Subscriber

IF THE MISSTATEMENT OF ELIGIBILITY WAS FRAUDULENT OR MATERIAL. The inadvertent receipt of any such premiums will not obligate Us to any potential claims. Upon determination of such receipt, We will refund those specific premiums to You within a reasonable amount of time.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/09/2012
Submitted Date	10/09/2012
Respond By Date	11/09/2012

Dear Brenda Dawson,

Introduction:

The Group Market Type selected includes an "Employer" group; therefore, a policy must be attached in order to approve this submission.

Objection 1

- Special Rider #1, B-OCCACC-TA-R-AMED (6/12) (Form)

Comments: We do not know everything that could be included in "changes in exposure of benefits. Riders and amendments must be signed by the policyholder if there is a reduction in benefits or an increase in premium due to an increase in benefits. Changes of such nature made using this rider must be signed and dated by the policyholder. Please add a place for the policyholders signature and date.

Objection 2

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Page 7, Reduction in Disability Income Benefits - The amount of any such reduction shall not be increased with any increase in the level of Social Security benefits payable that becomes effective after a claim commences. Please add this to the provision.

23-86-111(b)(3).

Objection 3

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Page 13, Section 5, Item 5, Modification of Premium Rates - Premium rates cannot be increased more than once in any 12-month period, except for the reason stated in your certificate.

Objection 4

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: No group accident policy will provide for a reduction in the amount of disability benefits unless the policy provides a minimum amount payable of \$50 per month. Please add this limitation to the Coordination of Benefits section or any other appropriate section/provision of the certificate. ACA 23-86-111(b)(1).

Objection 5

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Misstatement of Eligibility, Pg. 23.

23-79-107(a) Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

(1) Fraudulent; or

(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer.

Please revise this provision.

In addition, please add a statement that the statements made in the application (or enrollment form) are representations and not

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

warranties.

Objection 6

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Certificate Changes, Pg. 24. Please add to this provision that if there is a reduction in benefits or an increase in premiums the change must be made on a form signed by the policyholder.

Objection 7

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Physical Exam and Autopsy, Pg. 24. Please add to this provision that the autopsy will be paid at the insurer's expense.

Objection 8

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: The Audit provision on Page 24 seems to apply only to the policyholder and not the certificateholder. Please revise or remove this provision from the certificate.

Objection 9

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: The Inspection provision on Page 24 seems to apply only to the policyholder. Please revise or remove this provision from the certificate.

Objection 10

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Benefits and Examination Determination, Pg. 23. This provision does not comply with 23-79-203. Please revise this provision.

Objection 11

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Page 15, Fraudulent Claims. Please add to this provision a clarification that statements made in the application (or enrollment form) are representations and not warranties.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Pan-American Life Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/01/2012
Submitted Date	10/01/2012
Respond By Date	11/02/2012

Dear Brenda Dawson,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Special Rider #1, B-OCCACC-TA-R-AMED (6/12) (Form)

Comments: Please provide a statement of variability for this rider. It cannot be blank.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking #:	ICCI-128674182	State Tracking #:		Company Tracking #:	B-OCCACC-TA (6/12)
<hr/>					
State:	Arkansas	Filing Company:	Pan-American Life Insurance Company		
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness				
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)				
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)				

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/01/2012
Submitted Date	11/01/2012

Dear Donna Lambert,

Introduction:

Thank you for your letter.

Response 1

Comments:

Please find attached revised Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12). The required notice was added as item #1.

Related Objection 1

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Please add the required information to accompany policies as stated in ACA 23-79-138 and Bulletin 15-2009 to the certificate. If this information has been previously approved by amendment, please give the SERFF Tracking # and approval date of that amendment. I look forward to approving this submission when this small revision is made. Thank you for your cooperation.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 11-1-12.pdf	Date Submitted: 11/01/2012 By: Brenda Dawson
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/31/2012 By: Brenda Dawson
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By:
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12).pdf	Date Submitted: 09/17/2012 By: Brenda Dawson

No Rate/Rule Schedule items changed.

Conclusion:

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Thank you.
Sincerely,
Brenda Dawson

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/31/2012
Submitted Date	10/31/2012

Dear Donna Lambert,

Introduction:

Thank you for your letter.

Response 1

Comments:

The Group Policy was filed for informational purposes only. The Group Policy was issued to a Group located outside your states jurisdiction. The Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) is attached to the Certificate issued to the covered person. Under item B #5 Modification of Premium Rates, this provision states that premium rates will not be increased more than once in any 12 month period.

Related Objection 1

Applies To:

- Group Policy, B-OCCACC-TA-P (6/12) (Form)

Comments: Please revise the Premium Changes provision to limit premium changes to once in a twelve-month period.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include item C.1 Time Limit on Certain. Statement made in the application or enrollment are representations and not warranties.

Related Objection 2

Applies To:

- Amendatory Endorsement, B-OCCACC-TA-AE-AR (6/12) (Form)

SERFF Tracking #:	ICCI-128674182	State Tracking #:		Company Tracking #:	B-OCCACC-TA (6/12)
State:	Arkansas	Filing Company:	Pan-American Life Insurance Company		
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness				
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)				
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)				

Comments: Please add something in reference to the misstatement being fraudulent or material. Please consider something similar to the capitalized wording.

(c) Misstatement of Eligibility. We reserve the right to refund any premiums reported and paid to Us on any insured person who is found to not meet the Certificate definitions of a Subscriber

IF THE MISSTATEMENT OF ELIGIBILITY WAS FRAUDULENT OR MATERIAL. The inadvertent receipt of any such premiums will not obligate Us to any potential claims.

Upon determination of such receipt, We will refund those specific premiums to You within a reasonable amount of time.

Changed Items:

No Supporting Documents changed.

State: Arkansas Filing Company: Pan-American Life Insurance Company
 TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness
 Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)
 Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/31/2012 By: Brenda Dawson
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By:
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson
Previous Version								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12).pdf	Date Submitted: 09/17/2012 By: Brenda Dawson

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Brenda Dawson

SERFF Tracking #:	ICCI-128674182	State Tracking #:		Company Tracking #:	B-OCCACC-TA (6/12)
<hr/>					
State:	Arkansas	Filing Company:	Pan-American Life Insurance Company		
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness				
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)				
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)				

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/30/2012
Submitted Date	10/30/2012

Dear Donna Lambert,

Introduction:

Thank you for your letter. Please find attached a copy of the Group Policy. This Policy is being filed for informational purposes only. This Policy was issued to a group located outside the state of Arkansas.

Response 1

Comments:

Special Rider #1 B-OCCACC-TA-R-AMED-AR (6/12) was revised to include a space for the Group Policyholder signature.

Related Objection 1

Applies To:

- Special Rider #1, B-OCCACC-TA-R-AMED (6/12) (Form)

Comments: We do not know everything that could be included in "changes in exposure of benefits. Riders and amendments must be signed by the policyholder if there is a reduction in benefits or an increase in premium due to an increase in benefits. Changes of such nature made using this rider must be signed and dated by the policyholder. Please add a place for the policyholders signature and date.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Special Rider #1	B-OCCACC-TA-R-AMED (6/12)	CERA	Initial			AR PALIC B-OCCACC-TA-R-AMED-AR (6-12) Special Rider 10-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson
<i>Previous Version</i>								
1	Special Rider #1	B-OCCACC-TA-R-AMED (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-AMED (6-12) Special Rider 8-2-12.pdf	Date Submitted: 09/17/2012 By: Brenda Dawson

No Rate/Rule Schedule items changed.

Response 2

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

Related Objection 2

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Page 7, Reduction in Disability Income Benefits - The amount of any such reduction shall not be increased with any increase in the level of Social Security benefits payable that becomes effective after a claim commences. Please add this to the provision. 23-86-111(b)(3).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

Related Objection 3

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Page 13, Section 5, Item 5, Modification of Premium Rates - Premium rates cannot be increased more than once in any 12-month period, except for the reason stated in your certificate.

Changed Items:

- No Supporting Documents changed.
- No Form Schedule items changed.
- No Rate/Rule Schedule items changed.

Response 4

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

Related Objection 4

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: No group accident policy will provide for a reduction in the amount of disability benefits unless the policy provides a minimum amount payable of \$50 per month. Please add this limitation to the Coordination of Benefits section or any other appropriate section/provision of the certificate. ACA 23-86-111(b)(1).

Changed Items:

- No Supporting Documents changed.
- No Form Schedule items changed.
- No Rate/Rule Schedule items changed.

Response 5

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

Related Objection 5

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Comments: Misstatement of Eligibility, Pg. 23.

23-79-107(a) Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

(1) Fraudulent; or

(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer.

Please revise this provision.

In addition, please add a statement that the statements made in the application (or enrollment form) are representations and not warranties.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

Related Objection 6

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Certificate Changes, Pg. 24. Please add to this provision that if there is a reduction in benefits or an increase in premiums the change must be made on a form signed by the policyholder.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Related Objection 7

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Physical Exam and Autopsy, Pg. 24. Please add to this provision that the autopsy will be paid at the insurer's expense.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 8

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to delete this provision.

Related Objection 8

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: The Audit provision on Page 24 seems to apply only to the policyholder and not the certificateholder. Please revise or remove this provision from the certificate.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 9

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to delete this provision.

Related Objection 9

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: The Inspection provision on Page 24 seems to apply only to the policyholder. Please revise or remove this provision from the certificate.

Changed Items:

No Supporting Documents changed.

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 10

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to delete this provision.

Related Objection 10

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Benefits and Examination Determination, Pg. 23. This provision does not comply with 23-79-203. Please revise this provision.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 11

Comments:

Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12) was revised to include this information.

Related Objection 11

Applies To:

- Group Certificate, B-OCCACC-TA-C (6/12) (Form)

Comments: Page 15, Fraudulent Claims. Please add to this provision a clarification that statements made in the application (or enrollment form) are representations and not warranties.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

ICCI-128674182

State Tracking #:

Company Tracking #:

B-OCCACC-TA (6/12)

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Special Rider #1	B-OCCACC-TA-R-AMED (6/12)	CERA	Initial			AR PALIC B-OCCACC-TA-R-AMED-AR (6-12) Special Rider 10-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson
<i>Previous Version</i>								
1	Special Rider #1	B-OCCACC-TA-R-AMED (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-AMED (6-12) Special Rider 8-2-12.pdf	Date Submitted: 09/17/2012 By: Brenda Dawson
2	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson
<i>Previous Version</i>								
2	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12).pdf	Date Submitted: 09/17/2012 By: Brenda Dawson
3	Group Policy	B-OCCACC-TA-P (6/12)	POL	Other	Other Explanation : informational		PALIC B-OCCACC-TA-P (6-12) Master Policy - REDLINED 9-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson

No Rate/Rule Schedule items changed.

Conclusion:

Thank you

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Sincerely,
Brenda Dawson

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/01/2012
Submitted Date	10/01/2012

Dear Donna Lambert,

Introduction:

Thank you for your letter.

Response 1

Comments:

Please find attached the revised statement of variability. It was revised to include the Special Rider B-OCCACC-TA-R-AMED (6/12).

Related Objection 1

Applies To:

- Special Rider #1, B-OCCACC-TA-R-AMED (6/12) (Form)

Comments: Please provide a statement of variability for this rider. It cannot be blank.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	
Statement of Variables including special riders.pdf	
<i>Previous Version</i>	
Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	
Statement of Variables.pdf	

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

SERFF Tracking #:	ICCI-128674182	State Tracking #:		Company Tracking #:	B-OCCACC-TA (6/12)
State:	Arkansas	Filing Company:		Pan-American Life Insurance Company	
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness				
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)				
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)				

Thank you.
Sincerely,
Brenda Dawson

SERFF Tracking #:	ICCI-128674182	State Tracking #:		Company Tracking #:	B-OCCACC-TA (6/12)
<hr/>					
State:	Arkansas	Filing Company:	Pan-American Life Insurance Company		
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness				
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)				
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)				

Amendment Letter

Submitted Date: 10/30/2012

Comments:

Please find attached revised Amendatory Endorsement form B-OCCACC-TA-AE-AR (6/12). A revision was made to item A to replace the entire provision instead of replacing only the last sentence.

Under item B we corrected a typographical error.

In item C, the Fraudulent claims provision was removed as item 2(c) states that if a person doesn't meet the definition of subscriber, and premiums have been paid, then the Company will refund those premiums. It is not related to fraud.

For prior objection #8 and #9 we revised the Amendatory Endorsement to delete our revision. We respectfully disagree with the objection related to the Audit provision and the Inspection provision. Both provisions specifically refer to "you", which is the definitions is the subscriber, not the policyholder. The subscriber is the entity for which premiums and eligibility is based, and is there for the appropriate entity for both an audit and inspection.

For prior objection #10 we revised the Amendatory Endorsement to delete our revision. We respectfully disagree with this objection. The benefits and examination determination does not directly or indirectly deprive an insured of the right to trial by jury or any question of fact arising under the policy. It simply states that the Company may deny a claim if the subscriber does not agree to be examined by a physician to determine the medical necessity of a treatment. A subscriber has the right to take legal action subject to the actions of law provision if they refuse an examination.

For prior objection #11 we revised the Amendatory Endorsement to delete our revision. We respectfully disagree. The language is appropriately added to the time limit on certain defenses provision and is not pertinent to the Fraudulent Claims provision.

Changed Items:

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By:
<i>Previous Version</i>								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf	Date Submitted: 10/30/2012 By: Brenda Dawson
<i>Previous Version</i>								
1	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12).pdf	Date Submitted: 09/17/2012 By: Brenda Dawson

No Rate Schedule Items Changed.

No Supporting Documents Changed.

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Amendment Letter

Submitted Date: 09/18/2012

Comments:

Page 5 of the Certificate incorrectly listed South Carolina, the revised Certificate was revised to show on page 5 New Orleans, Louisiana.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Group Certificate	B-OCCACC-TA-C (6/12)	CER	Initial			PALIC B-OCCACC-TA-C (6-12) Trucking Certificate 8-2-12.pdf	Date Submitted: 09/18/2012 By:
<i>Previous Version</i>								
1	Group Certificate	B-OCCACC-TA-C (6/12)	CER	Initial			PALIC B-OCCACC-TA-C (6-12) Trucking Certificate 8-2-12.pdf	Date Submitted: 09/17/2012 By: Brenda Dawson

No Rate Schedule Items Changed.

No Supporting Documents Changed.

SERFF Tracking #:

ICCI-128674182

State Tracking #:

Company Tracking #:

B-OCCACC-TA (6/12)

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Form Schedule

Lead Form Number: B-OCCACC-TA-C (6/12)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 11/01/2012	Group Certificate	B-OCCACC-TA-C (6/12)	CER	Initial			PALIC B-OCCACC-TA-C (6-12) Trucking Certificate 8-2-12.pdf
2	Approved 09/21/2012	Aggregate Limit Rider	B-OCCACC-TA-R-AL (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-AL (6-12) Aggregate Limit Rider 8-2-12.pdf
3	Approved 11/01/2012	Special Rider #1	B-OCCACC-TA-R-AMED (6/12)	CERA	Initial			AR PALIC B-OCCACC-TA-R-AMED-AR (6-12) Special Rider 10-12-12.pdf
4	Approved 10/04/2012	Special Rider #1	B-OCCACC-TA-R-CAN (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-CAN (6-12) Special Rider - Cancellation 8-2-12.pdf

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Lead Form Number: B-OCCACC-TA-C (6/12)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
5	Approved 10/04/2012	Casual Laborer Rider	B-OCCACC-TA-R-CL1 (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-CL1 (6-12) Casual Laborer Rider #1(pre-determined delivery address) 8-2-12.pdf
6	Approved 10/04/2012	Covered Activity Rider - Casual Laborer	B-OCCACC-TA-R-CL2 (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-CL2 (6-12) Casual Laborer Rider #2 (inside sponsors location) 8-2-12.pdf
7	Approved 10/09/2012	Contingent Liability Coverage Rider	B-OCCACC-TA-R-CL (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-CL (6-12) Contingent Liability Policy Rider 8-2-12.pdf
8	Approved 10/04/2012	Covered Activity Rider - Courier Operation	B-OCCACC-TA-R-CO (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-CO (6-12) Courier Activity Rider 8-2-12.pdf

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Lead Form Number: B-OCCACC-TA-C (6/12)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
9	Approved 10/04/2012	Covered Activity Rider - Limousine Operation	B-OCCACC-TA-R-LIM (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-LIM (6-12) Limousine Activity 8-2-12.pdf
10	Approved 10/04/2012	Non Occupational Benefit Rider	B-OCCACC-TA-R-NON (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-NON (6-12) Non Occupational Rider ED-08 8-2-12.pdf
11	Approved 10/04/2012	Special Rider #1	B-OCCACC-TA-R-PAS (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-PAS (6-12) Passenger Accident Rider 8-2-12.pdf
12	Approved 10/04/2012	Pre-Existing Condition Rider	B-OCCACC-TA-R-PE (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-PE (6-12) Pre-existing Conditions Rider 8-2-12.pdf
13	Approved 10/04/2012	Covered Activity Rider - Trucking Operation	B-OCCACC-TA-R-TROP (6/12)	CERA	Initial			PALIC B-OCCACC-TA-R-TROP (6-12) Activity Rider 8-2-12.pdf

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Lead Form Number: B-OCCACC-TA-C (6/12)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
14	Approved 09/21/2012	Application	B-OCCACC-TA-P-APP (6/12)	AEF	Initial			B-OCCACC-TA-P-APP (6-12) Group Application 8-2-12.pdf
15	Approved 11/01/2012	Amendatory Endorsement	B-OCCACC-TA-AE-AR (6/12)	CERA	Initial			AR B-OCCACC-TA-AE-AR (6-12) 11-1-12.pdf
16	Approved 11/01/2012	Group Policy	B-OCCACC-TA-P (6/12)	POL	Other	informational		PALIC B-OCCACC-TA-P (6-12) Master Policy - REDLINED 9-12-12.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

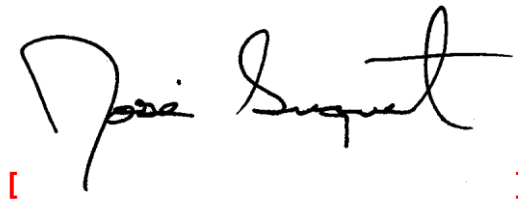
PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana
(Hereafter called We, Us, Our or Ours)

BLANKET GROUP OCCUPATIONAL ACCIDENT CERTIFICATE OF INSURANCE

The benefits of the Group Policy are described in this booklet. Pan-American Life Insurance Company certifies that it has issued the policy numbered as shown in Item # 2 of the Schedule to the Policyholder shown in Item # 1 of the Schedule.

This booklet is a certificate of insurance only when You are insured under the policy.



[Chairman of the Board
President and Chief Executive Officer]

All States except Texas: **IMPORTANT NOTICE: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

Texas Residents: **THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

West Virginia Residents: **Right to Return** – You have the right to return this certificate to us or our agent for cancellation within 10 days of its delivery to you. The full amount of Your premium will be refunded to you, if, after examination of this certificate you are not satisfied for any reason.

Arizona Residents: **NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL THE BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.**

Florida Residents:

Primarily the law of a state other than Florida governs the benefits of the policy providing your coverage

TABLE OF CONTENTS

Schedule	P. 2		
Section 1 - When Coverage Starts	P. 5	Section 5 - Premium Provisions	P. 12
Section 2 - When Coverage Stops	P. 5	Section 6 - Claim Provisions	P. 13
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OCCUPATIONAL ACCIDENT BENEFITS ONLY

SCHEDULE

This Schedule is a very brief summary of the benefits.

Please read the entire Certificate for a more complete description of the benefits outlined in this Schedule.

- Item 1. Policyholder: **[Professional Association of Independent Contractors
12850 Spurling Road, Suite 170
Dallas, TX 75230]**
- Item 2. Policy Number: **[12345]** Item 2A: Participant/Sponsor Number: **[12345]**
- Item 3. Participant Sponsor: **[ABC Company]**
- Item 4. Participant/Sponsor's Effective Date: **[mm/dd/yyyy] 12:01AM**, Standard Time at the address of the Participant/Sponsor. Participant/Sponsor's Expiration Date: **[mm/dd/yyyy] 12:01AM**, Standard Time at the address of the Participant/Sponsor.
- Item 5. Covered Subscriber: As named and reported on the monthly census by the Participant/Sponsor
- Item 6. Subscriber's SS #: As on file
- Item 7. Subscribers Enrollment Date: As on file
- Item 8. Eligible Classes: As shown below and defined in the Covered Activity Rider:

	<u>Covered</u>	<u>Not Covered</u>
Class 1 - Owner/Operator	<u>[X]</u>	<u>[X]</u>
Class 2 - Scheduled Co-Driver	<u>[X]</u>	<u>[X]</u>
Class 3 - Scheduled Contract Driver of Owner/Operator	<u>[X]</u>	<u>[X]</u>
Class 4 - Scheduled Laborer	<u>[X]</u>	<u>[X]</u>
Class 5 - Independent Contractor (Not otherwise classified)	<u>[X]</u>	<u>[X]</u>

- Item 9. Covered Activities - Refer to Covered Activity Rider – [Trucking Operation, Courier Operation, Limousine Operation]
- Item 10. Coverage Basis: Insurance for Subscribers is limited to Occupational-Related Injuries only.
- Item 11. Amounts of Insurance:

☐ Accidental Death & Dismemberment Benefits:

- AD&D Principal Sum: **[\$50,000, \$100,000, \$150,000, 250,000, \$300,000]**
- AD&D Maximum Any One Loss: **[\$50,000, \$100,000, \$150,000, 250,000, \$300,000]**
- AD&D Reporting Period: Claims must be reported within: **[365]** days from date of accident

Accidental Death Benefit: If Injury to the Subscriber results in death within [365] days of the date of the Accident that caused the Injury, We will pay the Principal Sum as indicated below:

Installment Payment Option for Death Benefits: Yes **[X]** No **[X]**

- ☐ Initial Death Benefit: [\$5,000, \$10,000, \$15,000, 25,000, \$30,000, \$50,000] Remaining balance is payable as a Survivor's Benefit @ [1%] per month for [100] months or until satisfaction of the Survivor's Benefit; *whichever occurs first*.
- ☐ If No is checked above, the benefit for Accidental Death benefit will be paid in one Lump Sum.

Accidental Dismemberment Benefit: If injury to the Subscriber results within [365] days of the date of the Accident that caused the Injury, in any one of the Losses specified below, We will pay the percentage of the Principal Sum shown in the following Schedule of Losses for that Loss.

Schedule of Accidental Death & Dismemberment Benefits for Loss of:	Principal Sum
Life.....	[100%]
Both Hands or Both Feet.....	[100%]
Sight of Both Eyes.....	[100%]
One Hand and One Foot.....	[100%]
One Hand and the Sight of One Eye.....	[100%]
One Foot and the Sight of One Eye.....	[100%]
Speech and Hearing in Both Ears.....	[100%]
One Hand or One Foot.....	[50%]
Speech.....	[50%]
The Sight of One Eye.....	[50%]
Hearing in One Ear.....	[25%]
Thumb and Index Finger of Same Hand	[25%]

Functional Loss of Use: If Injury to the Subscriber results within 365 days of the date of the Accident that caused the Injury in any one of the losses specified below, We will pay the percentage of the Principal Sum shown below for that Loss:

Functional Loss of Use:	Principal Sum
Use of 4 Limbs	[100%]
Use of 3 Limbs	[75%]
Use of 2 Limbs	[50%]
Use of 1 Limb	[25%]

For purposes of the AD&D benefits as scheduled above, only one benefit, the highest, will be paid if You suffer more than one loss including Life, Dismemberment or Functional Loss of Use that result from the same Accident. The Functional Loss of Use Benefit will be paid according to the Installment Payment Option listed on the Schedule if the Installment Payment Option is selected.

- ☐ **Accidental Disability Benefits:**
- Disability Waiting Period: [7, 14, 28] days
 - Retroactive Benefits: No [X] Yes [X]
 - Percent of Average Weekly Wages: [66 2/3%, 70%]
 - Maximum Weekly Benefit: [\$300, \$400, \$500, \$600, \$700]
 - Disability Reporting Period: Claims must be reported within: [90] days from date of accident

	Covered	Not Covered	Maximum Payment Period
<input type="checkbox"/> Temporary Total Disability	<u>[X]</u>	<u>[X]</u>	up to [26, 52, 104, 156] weeks
<input type="checkbox"/> Permanent Total Disability	<u>[X]</u>	<u>[X]</u>	up to Age [65, 70]

☐ **Accident Medical Expense Benefits:**

- **Maximum Medical Benefit Each Person Per Occurrence:** **[\$100,000, \$250,000, \$300,000, \$2,000,000]**
- **Medical Deductible Each Person Per Occurrence:** **[\$0.00, \$100, \$250, \$500]**
- **Medical Reporting Period:** Claims must be reported within: **[90]** days from the date of the accident
- **Medical Incurral Period:** Benefits are payable for: **[26, 52, 104, 156]** weeks from the date of the accident
- **First Expenses:** Must be incurred within: **[90]** days from the date of the accident

Item 12. Additional Conditions and Limitations:

1. Premium Payment Mode **[Daily, Weekly, Monthly, Annual, Per Trip, Other]**
2. Premium Calculation Mode **[15th of the Month, Other]**
3. Age Limit (see Uniform Provisions for more details) **[AGE 65, 70]**

Item 13. Supplemental Coverage Provided for:

	<u>Covered</u>	<u>Not Covered</u>
1. Occupational Disease	[X]	[X]
2. Cumulative Trauma	[X]	[X]
3. Sojourn/Personal Deviation	[X]	[X]
4. Hernia	[X]	[X]

Item 14. Maximum Limit Each Subscriber -- Per Occurrence

We will not pay more than **[\$100,000, \$250,000, \$300,000, \$500,000, \$1,000,000, \$2,000,000]** for all benefits combined (Accidental Death and Dismemberment, Accidental Disability and Accident Medical benefits combined) for each *Subscriber*.

Item 15. Forms, endorsements and riders attached to and made a part of this policy at issuance:
[Aggregate Limit, Trucking Operation, Non-Occupational, Pre-Existing Conditions, Casual Laborer Provision, Passenger Accident]

This Certificate is not binding upon Us until countersigned below by *Our Authorized Representative*.

Authorized Representative

Date Signed

PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana

(Hereafter called *We, Us, Our or Ours*)

Italicized words in this Certificate mean those terms are defined in Section 7-Definitions.

SECTION 1 – WHEN COVERAGE STARTS

When a Participant's Coverage Commences

A Participant's coverage will begin on the Participant's Effective Date.

Eligibility and When a Subscriber's Coverage Commences

The Eligibility is identified by the Eligible Class descriptions as shown on the **Schedule** and defined in the Covered Activity Rider. Coverage under the Certificate begins only after a Request for Insurance Form is completed and filed with and approved by *US* within 30 days.

Subscriber Deferred Effective Date: If *You* are away from work because *You* are disabled on the date coverage would start, coverage will not start until *You* are no longer *disabled* and *you* return to active work and only after a Request for Insurance Form is filed with and approved by *Us*.

SECTION 2 – WHEN COVERAGE STOPS

When a Participant's Coverage Stops

A Participant's coverage under the *group policy* shall terminate when:

- We give advance written notice of termination of the *group policy* for any reason, or
- the *Policyholder* requests in writing for the *group policy* to be terminated, or
- the *Participant* fails to pay the required premium when due (subject to any Grace Period), or
- when the *Participant* requests to terminate its participation under the *group policy*.

When a Subscriber's Coverage Stops

You may request that *Your* coverage be terminated by completing the necessary written notice and forwarding it to the *Participant/Sponsor*. The effective date of termination will be the earliest of the following:

- the date the *Participant/Sponsor* receives a written request for termination from *You*; or
- when *You* are no longer in an Eligible class; or
- when *You* stop making payments for the coverage (subject to any Grace Period); or
- when the *group policy* terminates; or
- when the *Participant/Sponsor* stops participating in this insurance; or
- when any applicable Age Limit is attained.

SECTION 3 – BENEFIT PROVISIONS

Benefits hereunder are only payable for loss sustained by a covered *Accident*. **NO BENEFITS ARE PAYABLE IN CONJUNCTION WITH AN ILLNESS OR SICKNESS, AS DEFINED HEREIN.**

Coverage A, B, C, or D applies only when indicated on the Schedule that the particular coverage is provided.

Coverage A. ACCIDENTAL DEATH BENEFIT

If *You* suffer death within [365] days after a covered Accident, Accidental Death Benefits will be paid to *Your* eligible beneficiary(ies). The benefit payable will be in accordance with the terms, conditions, limitations and exclusions of this *Certificate* and any Maximum Benefit as shown in the **Schedule**.

Installment Payment Option

[If the Installment Payment Option is shown in the **Schedule** as YES then any death benefits will be paid in monthly installments. *Your* beneficiary may not elect payment in one sum after *Your* death.

The initial Death Benefit is shown in the **Schedule**. The remaining balance will be payable as a Survivor's Benefit in monthly installments of [1%] per month for a period of [100] months after the initial payment has been made or until the satisfaction of the Survivor's Benefit; *whichever occurs first*.

If a *Subscriber* dies within [365] days after a covered Accident and before attaining the Age Limit and is survived by an eligible beneficiary, the Survivor's Benefit will be payable. This benefit will be paid in accordance with the terms, conditions, limitations and exclusions of this *Certificate*, and subject to the following:

- If a *Subscriber* is survived by a *spouse*, the *spouse* will receive a monthly benefit until he/she dies, remarries, enters into a common-law or otherwise meretricious relationship, or until the Maximum Benefit is paid, whichever occurs first;
- If the *spouse* is no longer eligible to receive this benefit, then any eligible *Dependent Child(ren)* will receive this benefit until no longer eligible, or until the Maximum Benefit has been paid, whichever comes first. Benefits to any *Dependent Child(ren)* ceases upon the child's attainment of age [19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university];
- If there are no eligible beneficiaries, no Survivor's benefit will be paid.

If the Installment Payment Option is shown in the **Schedule** as No then any death benefits will be paid in a Lump Sum.]

Beneficiary

A person becomes a beneficiary only if *You* have named the person(s) as a beneficiary on the RFI or other approved beneficiary form. Beneficiary designations may be changed by filing out a Change of Beneficiary form. If no beneficiary is named, applicable Death benefits will be paid to *Your estate*.

Coverage B. – ACCIDENTAL DISMEMBERMENT BENEFIT

The benefits payable will be in accordance with all of the terms, conditions, limitations and exclusions of this *Certificate* including the attached **Schedule**. The loss must result directly and solely from such covered Accident and be independent of disease or bodily infirmity.

The Principal Sums for Dismemberment and/or Functional Loss of Use are shown in the **Schedule**.

The term "Dismemberment" means a complete separation of a limb from the body. "Hearing or Speech Loss" means the total and irrecoverable loss of hearing or speech. "Loss of Hand" means removal at or above the wrist joint. "Loss of Foot" means removal at or above the ankle joint. "Loss of an Eye" means the total and irrecoverable loss of sight. "Loss of Thumb and Index Finger of the Same Hand" means the actual, permanent and complete severance through or above the metacarpophalangeal joints. "Functional Loss of Use" means complete paralysis of the entire limb which cannot be recovered.

If more than one Dismemberment, Loss of Life or Functional Loss of Use results from any one accident, the benefit payable is the total percentage of the Principal Sums indicated above. However, the most we will pay for all loss resulting from one accident is 100% of the Principal Sum. The Functional Loss of Use Benefit will be paid according to the Installment Payment Option listed on the Schedule if the Installment Payment Option is selected.

Coverage C.— ACCIDENTAL DISABILITY BENEFIT

We will pay an Accidental Disability Benefit for each week of *Your* disability as stated in the **Schedule**. Payment will not be made during any *Waiting Period*, unless otherwise indicated on the **Schedule**. Once the applicable *Waiting Period* is satisfied, benefits will be payable as shown in the **Schedule**.

In order to be considered under this Benefit provision, *Disability* must (1) result from a covered *Accidental Injury*, (2) begin within the Disability Reporting Period shown in the **Schedule**, (3) require the ongoing care of a legally qualified *physician* and (4) prevent *You* from engaging in work for compensation, wage or profit.

The definition of *Total Disability* will be further limited in scope by the following modes:

- **Temporary Total Disability**, a benefit, up to the Maximum Weekly Benefit shown in the **Schedule**, will be payable for *Your* inability to perform all of the substantial and material duties of *Your* regular occupation as defined in *Your Covered Contract* for up to the Maximum Payment Period shown in the **Schedule**: or
- **Permanent Total Disability**, if *You* are still disabled after the Maximum Payment Period for Temporary Total Disability, a benefit will be payable, up to the Maximum Payment Period for *Permanent Total Disability* as shown in the **Schedule**, if

You:

- Cannot engage in any work for pay or profit, and are unable to perform all of the substantial and material duties of ANY occupational or employment which *You* might qualify for by reason of education, training or experience, and
- Are granted a Total Disability Award status and *You* start receiving disability payments by the Social Security Administration for such *Total Disability*. If *You* are ruled ineligible based on the status or *You* are ineligible for Social Security Administration disability payments for any reason, *You* will also be deemed ineligible for payments under this *Permanent Total Disability* benefit.

For Temporary Total Disability, the *Accidental* Disability Benefit will be payable for the duration of the Disability after satisfying any applicable *Waiting Period*. Any Total Disability of less than one Week, one-seventh of the Weekly Benefit will be payable per full day of Disability. For *Permanent Total Disability*, the monthly benefit will be equal to 4.3 times the Weekly benefit.

Separate periods of Disability resulting from the *same or related causes* will be considered one period of *Disability* unless separated by *Your* return to active work or until *You* can perform the daily functions of a person of like age in good health for at least six (6) consecutive months.

Separate periods of Disability resulting from *unrelated causes* will be considered one period of Disability unless separated by *Your* return to active work or until *You* can perform the daily functions of a person of like age in good health for at least one full day.

The Maximum Weekly Benefit payable will be a percentage of *Your* Average Weekly Wage. At *Our* discretion, benefits may be paid on a monthly or bi-monthly basis, instead of weekly. From time to time, *Your* status will be reviewed and may require an accounting of earnings and/or proof of continued disability. *Your* failure to furnish any such required information within 30 days of written notice may result in termination of coverage and/or benefits.

Reduction in Disability Income Benefits

The amount of Total Disability Income Benefits will be reduced by the amount of any Social Security benefits payable on account of such *disability*. This amount will include any benefits payable for dependents. Cost-of-living increases in Social Security payments effective after the correct Social Security benefit has been determined will be used to reduce *Our* Disability Income Benefit.

Coverage D.—ACCIDENT MEDICAL EXPENSE BENEFITS

If You suffer *Bodily Injury* in a **covered** *Accident* that requires medical attention, We will pay for *medically necessary* services or supplies as provided for herein. **There is no coverage under this benefit for Your sickness, illness or ordinary disease of life (by whatever named called).** However, if You develop an *illness* or *disease* that is the result of and directly related to *Bodily Injury* which first occurred from a **covered Accident**, benefits will be payable as provided for herein. In any case, medical benefits payable are limited to expenses *Incurred* within the time frame specified under the **Medical Incurral Period** (as shown in the **Schedule**) or until any Maximum Benefit (as shown in the **Schedule**) has been paid, **whichever occurs first**.

Subject to Utilization Management, payment for *medically necessary* and appropriate treatment will be made in accordance with this *Certificate*. These expenses must be *Incurred* during the **Medical Incurral Period** shown in the **Schedule** and exceed the *Accident Medical Deductible*, if any, described herein, up to any Maximum Benefit. This benefit is payable regardless of where the expenses are *Incurred*, whether in or out of the *hospital*, subject to Utilization Management as defined herein.

Charges: Payments for covered expenses are made based upon *usual, customary and reasonable* criteria that is procedure or service specific and calculated by geographic location. Benefits are payable only up to *usual, customary and reasonable* levels; amounts in excess of this amount will not be covered.

Accident Medical Deductible: For each *Accident*, there may be a *Deductible*, as shown in the **Schedule**.

HOSPITAL EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers *Your* stay in facilities including a general *hospital*, up to the stated limits shown in the **Schedule**. For stays in an *Extended Care Facility/Rehabilitation Facility*, this benefit covers the average room and board costs and miscellaneous services. The confinement must begin within 14 days of discharge from a *hospital confinement* of at least 3 days for the same or related conditions, provided a legally qualified *physician* is supervising such care and certifies in writing that the patient continues to need skilled nursing care or supportive therapeutic services as part of a regimen of medical care.

SURGICAL PROCEDURES EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers the cost of surgical procedures undergone by *You* as a result of a covered *Accidental Injury*, up to the amount customarily charged for the procedure in the geographic locality where it is performed.

DENTAL PROCEDURES AND ORAL SURGERY

Dental procedures are not covered, except for the prompt, necessary repair to a *sound natural tooth* which results from a **covered Accidental Injury**. Such *injuries* must occur while covered under this *Certificate*. Subject to the Accident Medical provisions set forth herein, **certain oral surgical procedures are covered**. Covered procedures are limited to the following:

- excision of unerupted, partly erupted or impacted teeth
- repair of a fractured or dislocated jaw
- osseous surgery
- maxillofacial surgery

ANESTHESIA EXPENSE

Subject to the Accident Medical provisions set forth herein this benefit covers the costs of a legally qualified *physician* (who is not the attending surgeon or assistant surgeon) who performed anesthetic procedures, in connection with a surgical procedure for which benefits are payable due to a **covered Accident**. This benefit also covers the cost of the anesthetic itself. These charges are paid on a *usual, customary and reasonable* basis.

PHYSICIAN SERVICES EXPENSE

Subject to the Accident Medical provisions set forth herein, visits by a *physician* for treatment of a covered *Accidental Injury* while *You* are a registered bed patient in a *hospital*, will be paid on a *usual, customary and reasonable* basis. *Physician* care and treatment, including consultations, will be paid on a *usual, customary and reasonable* basis.

DIAGNOSTIC PROCEDURES EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers radiological or laboratory procedures recommended by a *physician* or surgeon for diagnosis in connection with a covered *Accidental Injury*. Radiological and laboratory procedures must be rendered, where possible, at centers other than a *hospital*. Venipuncture is not covered. This *Certificate* covers up to *usual, customary and reasonable* charge for *Accidents*.

PRESCRIPTION DRUG EXPENSE

Coverage for expenses *Incurred* by *You* for *prescription drugs* shall be considered payable if necessary for the care and treatment of a covered *Accidental Injury* and only when prescribed by a *Physician* when:

- Confined as an *inpatient* in a *hospital*; or
- Administered as part of a *physician's* office visit.

Expenses *Incurred* are payable subject to the *Deductible*, if any. No *prescription drug* expense benefits shall be paid for expenses related to:

- therapeutic devices or appliances (unless *We* authorize coverage under Alternative Treatment Expense)
- any prescription which *You* are entitled to receive without charge from any municipal, state or federal program
- any prescription refilled in excess of or dispensed after one (1) year from the *Physician's* original order
- immunization agents
- *experimental* drugs

HOME HEALTH CARE EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers certain services or supplies furnished to *You* in *Your* home in connection with a covered *Accidental Injury*. The services and supplies must be furnished under a program approved in writing by the attending *physician*, as an alternative to continued *hospital* care, and must be provided by a certified *Home Health Care Agency* and pre-approved by *Us*.

The services and supplies to which this benefit apply are:

- Part-time or intermittent nursing care by a Registered *Nurse*, or by a Licensed Practical *Nurse* under the supervision of a Registered *Nurse* if the services of a Registered *Nurse* are not available.
- Part-time or intermittent home health aide services which consist primarily of patient care of a medical therapeutic nature by other than a Registered or Licensed Practical *Nurse*;
- Physical therapy, occupational therapy, and speech therapy provided by the Home Health Agency;
- Medical supplies, drugs and medications prescribed by a *physician*, and laboratory services by or on behalf of a *hospital*, to the extent such items would have been covered under the *Hospital* Benefit if *You* had remained in the *Hospital*;

For determining the limit of benefits with respect to services set forth in items 1, 2 and 3 above, each visit by a member of a home health care team shall be considered as one home healthcare visit and four hours of home health aide service shall be considered as one home health care visit.

No payments will be made for:

- Services or supplies of a *Home Health Care Agency* furnished to anyone eligible for *Medicare*, or
- Services or supplies not included in a home healthcare plan, or

- Services of a person who ordinarily resides in the home, or is a member of the family, or
- Transportation services, and services and supplies provided to an individual primarily to assist him/her in the activities of daily living, or
- Any period during which *You* are not under the continuing care of a *physician*, or
- Expenses for services and supplies not related to medical care or treatment.

EMERGENCY ROOM EXPENSE

Subject to the Accident Medical provision set forth herein, emergency room costs for the treatment of an *injury* arising from a covered *Accident* that requires *Emergency Care* as defined by this *Certificate*, are covered on a *usual, customary and reasonable* basis.

COVERED MEDICAL EXPENSE

Subject to the Accident Medical provisions as set forth herein, the following are Eligible Expenses under this *Certificate*:

Hospital Charges for:

- the actual Room and Board expenses *Incurred* subject to *usual, customary and reasonable* charges.
- the actual expense *Incurred* for confinement in an Intensive Care Unit, Cardiac Care Unit or Burn Unit.
- miscellaneous *Hospital* services and supplies during *hospital confinement*.

UC&R Charges *Incurred* as follows:

1. for confinement in a *Rehabilitation Facility*,
2. for confinement in a *Convalescent* or *Skilled Nursing Facility*. However, such expenses are limited as follows:
 - Charges will be considered only if confinement begins within [14] days after a *Hospital Confinement* of at [least three (3) consecutive days.]
 - The Attending *Physician* certifies that confinement is *medically necessary*. Only charges *Incurred* in connection with care related to the covered *Accidental Injury* for which a *Subscriber* was confined will be eligible.
3. Surgical Procedures, as follows:
 - For *medically necessary* Surgical Procedures.
 - When two or more Surgical Procedures occur during the same operation, the Eligible Expense for all charges are as follows:
 - Charges for multiple surgical procedures performed during the same operative session which do not require separate incisions are handled as follows: the covered eligible expense for the greater procedure will be considered in full; the covered eligible expense for the next lesser procedure will be considered at 50%; and the covered eligible expense for any additional procedures will be considered at 25%.
 - When an incidental procedure is required because of a covered *Accident* and performed through the same incision, the Eligible Expense is the *UC&R* fee for the major surgical procedure only.
 - When an assistant surgeon is required to render technical assistance at an operation, the Eligible Expense for such services shall be limited to 20% of the *UC&R* charge of the surgical procedure.
 - *UC&R* charges for the following oral surgery procedures:
 - Open or closed reduction of a fracture or dislocation of the jaw;
 - Osseous surgery;
 - Maxillofacial surgery;
 - *Accidental Injury* to a sound, natural tooth
 - *UC&R* charges for reconstructive surgery; only for the following situation:
 - The treatment within six (6) months of a covered *Accidental Bodily Injury* sustained and treated while a *Subscriber*.

UC&R Charges, as follows:

- For the services of a legally qualified *physician* for medical care and/or surgical treatment including office, home visits, *hospital inpatient* care, *hospital outpatient* visit/exams, clinic care, and surgical opinion consultations;
- of registered *nurses* (RNs) or licensed practical nurses (LPNs) for private duty nursing;
- for the treatment or services rendered by a licensed Physician or Occupational Therapist under direct supervision of a *Physician* in a home setting or at a facility or institution whose primary purpose is to provide medical care for a covered *Accidental Injury*;
- of a legally qualified *Physician* or qualified Speech Therapist under direct supervision of a *Physician* for restorative speech therapy for speech loss or impairment due to a covered *Accidental Injury*, or due to surgery performed on account of a covered *Accidental Injury* other than a functional nervous disorder;
- for professional ambulance service to the *Hospital* in an emergency situation when a *Subscriber* is subsequently admitted as an *inpatient*; and transport between medical facilities when *medically necessary*;
- for drugs requiring the written prescription of a licensed *Physician*; such drugs must be necessary for the treatment of a covered *Accidental injury*;
- for radiological services, microscopic tests and laboratory tests;
- for the processing and administration of blood components, but not for the cost of the actual blood or blood components if replaced;
- for physical and manipulative therapy when such therapy is part of a *physician*-approved *Home Health Care Plan*;
- for oxygen and other gases and their administration;
- for electrocardiogram, electroencephalograms, pneumoencephalogram, basal metabolism tests, or similar well established diagnostics generally approved by *Physicians* throughout the United States;
- for the cost and administration of an anesthetic;
- for dressings, sutures, casts, splints, trusses, crutches, braces, and other necessary medical supplies;
- for rental of a wheelchair, *hospital* bed, ventilator, or other *durable medical equipment* required for therapeutic Use, or the purchase of this equipment if economically justified, whichever is less;
- for non-dental *prostheses* and *appliances* including artificial limbs, eyes, or larynx, to replace limbs or eyes lost while covered under the *Certificate*, but not the replacement thereof unless the replacement is necessary because of physiological changes;
- for services of an ambulatory or *outpatient* surgical center;
- Charges made by a *Home Health Care Agency* for care in accordance with a *Home Health Care Plan*. Such expenses include:
 - Part-time or intermittent nursing care by a registered *nurse* (R.N.), a licensed practical *nurse* (L.P.N.), a licensed vocational *nurse* (L.V.N.), or public health *nurse* who is under the direct supervision of a registered *nurse*,
 - Home health aides, and
 - Medical supplies, drugs and medicines prescribed by a *Physician*, and *durable medical equipment* prescribed by a *Physician*.

Specifically excluded from coverage under the Home Health Care benefit are the following:

- Services and supplies not included in the *Home Health Care Plan*
- Services of a person who ordinarily resides in *Your* home, or is a *close relative* of *Yours*,
- Transportation services,
- *Custodial Care* and housekeeping.

Home Health Care Visit means a visit by a member of a Home Health Care team. Each such visit that lasts for a period of four (4) hours or less is treated as one Home Health Care Visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one Home Health Care Visit;

- for Dental Services rendered by a *Physician* for treatment of an *Injury* to a sound, natural tooth if:
 - The *injury* is caused by a covered *Accident* sustained while a *Subscriber*;
 - All treatment is rendered within six (6) months of the covered *Accident*; and
 - All treatment is rendered while a *Subscriber*;
- for hyperalimentation or Total Parenteral Nutrition (TPN) for persons recovering from or preparing for surgery;
- for the services of a qualified physiotherapist.

SECTION 4 – LIMITATIONS AND EXCLUSIONS

Limitations Applicable to all Benefits.

Coverage hereunder shall not apply to any person who is acknowledged as a statutory employee of the *Participant/Sponsor* or any *Subscriber* prior to a claim being filed under this *Certificate* or to any claim brought by employees of the *Subscriber* who are not considered to be *Independent Contractors*.

No payment of benefits will be made:

1. [for, or in connection with, an *Occupational Disease* or *Cumulative Trauma* arising out of, or in the course of, any employment for wage or profit (unless specifically stated in the **Schedule** as 'covered');]
2. [for, or in connection with, an *Illness* or an *Injury* if the Subscriber is deemed to be an employee and covered under any Worker's Compensation or similar state or federal law;]
3. [for treatment, services or supplies received in a *Hospital* owned or operated by the United States Government;]
4. [for charges which *You* are not legally required to pay or for which no charge or payment would have been required if coverage was not in force;]
5. [which are in excess of *usual, customary and reasonable* charges; or which are determined to be inappropriate or not *medically necessary*;]
6. [for, or in connection with, *custodial care*, education or training;]
7. [for, or in connection with, reconstructive surgery or treatment; except as provided for herein;]
8. [as a result of war, declared or undeclared;]
9. [for eyeglasses, contact lenses and hearing aids, and examinations for their prescriptions and fitting including charges for surgical procedures for the correction of visual refractive problems (radial keratotomy), except for the replacement of eyeglasses, contact lenses or hearing aids which are damaged in a covered Accident;]
10. [for nursing, medical or surgical care or treatment rendered by a family member, including, but not limited to, a *spouse, child, mother, father, brother, sister, parent of spouse, aunt, uncle, or son-in-law/daughter-in-law*;]
11. [for, or in connection with dental services or supplies, except as provided for herein;]
12. [to the extent that *You* are reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any government sponsored program, including, but not limited to, *Medicare* or *Social Security*;]
13. [for any loss directly resulting from the commission of or attempt to commit a felony or directly resulting from being engaged in an illegal act or occupation;]
14. [for devices, equipment and supplies that are not durable medical equipment or prostheses;]
15. [for services paid, payable or required to be provided as Basic Reparations Benefits under any No-Fault Automobile Insurance Law. An uninsured or underinsured motorist will be considered *self-insured* for bodily injury expenses. We will not be required to extend benefits which are required under any No-Fault Automobile Insurance Law;]
16. [for, or in connection with, *experimental* procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;]
17. [for *experimental drugs* or substances not approved by the Food & Drug Administration, or for drugs labeled: "*Caution: Limited by Federal Law to Investigational Use*";]
18. [for non-medical *hospital* expenses such as newspapers, guest trays, beauty shop services, cots, guest accommodations, admission kit, rental of telephones, radios, televisions or any other items solely for personal use or comfort;]
19. [for care, treatment, services, supplies, materials, and/or equipment which are not *medically necessary* or which are inappropriate for the diagnosis and related care/treatment of a covered Accidental Injury;]
20. [by any provider of medical services for the time spent traveling in the course of rendering medical care;]
21. [for the services of nutritionists, acupuncturists, massage therapists, herbalists, or other unlicensed allied health professionals;]
22. [for suicide, attempted suicide or self-inflicted *Bodily Injury* while sane or insane;]
23. [for failure to complete scheduled visits and charges for completion, copying or completion of any claim form, operative report or medical records;]
24. [for a *Bodily Injury* while a *Subscriber* is:
 - Intoxicated (A *Subscriber* will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to

- be *under the influence* of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the *Bodily Injury* occurs); or
 - *Under the influence* of any narcotic, unless such narcotic was prescribed by a Physician and taken in accordance with the prescribed dosage.]
25. [for medical care or treatment received while incarcerated in a local, state or federal facility. Benefits as shown on the **Schedule** will be terminated as of the first day of incarceration;]
 26. [for sickness, disease or bacterial infections;]
 27. [for purposely self-inflicted *Injury* or any *Injury* resulting from a provoked attack;]
 28. [for any *Bodily Injury* incurred while riding or driving in any kind of organized race for profit;]
 29. [for any *Bodily Injury* incurred while travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,
 - while being used for any test or experimental purpose; or
 - while a *Subscriber* is operating, learning to operate or serving as a member of a the crew thereof; or
 - while being operated by or for or under the direction of any military authority, other than transport type aircraft];
 30. [when skydiving, parasailing, bungee-jumping, or any similar activity: or]
 31. [for prostatitis or hemorrhoids not directly related to an accident; or]
 32. [for any amount of a covered claim that exceeds the Combined Single Limit. The Combined Single Limit is shown in the Schedule of Benefits; or]
 33. [for "*Pre-existing Conditions*". The term "*Pre-existing Condition*" means an illness or injury for which a covered *Subscriber*:
 - Incurred charges
 - Received medical treatment
 - Consulted a *physician*, or
 - Took prescribed drugs
 within 12 months before he or she became insured under a given benefit section of this policy.]

SECTION 5 – PREMIUM PROVISIONS

1. **Premium Remittance and Due Date.** Premiums are payable to *Us* or *Our* authorized representative as shown on the **Schedule**. Premiums are fully earned on the [first] day of each month.
2. **Calculation of Premiums Due.** A monthly report is required as of the first day of each month through the entire term of this *Certificate*. The report must indicate the name, address, social security number and all other required information for each *Subscriber*. The monthly premium due is determined by applying the monthly rate in force per *Subscriber* to the total number of covered *Subscribers* shown on the monthly report.

The premium calculation mode (as shown in the **Schedule**) determines the method of use to determine the premiums charged. If indicated as "15th of the Month" then *Subscribers* added after the 15th of the month do not pay any premium for that month. If the mode is indicated as "Pro-rata" then *Subscribers* who are added during the month pay a pro-rata premium based on the number of days covered during that month times the daily rate (daily rate equals the monthly rate divided by 30). Premiums are fully earned as of the first day of each month. There are no return premiums.

3. **Past Due Premiums.** Premiums are consider in arrears on the 2nd day of each month.
4. **Grace Period.** There is a [thirty-one (31)] day Grace Period for payment of all premiums except for the premium required to effect coverage. Coverage under the *Certificate* will terminate at the end of the Grace Period unless We receive written notice from the *Subscriber* to terminate it earlier. This *Certificate* shall remain in full force during the Grace Period. If the required premium is not paid and received by the end of the Grace Period, coverage will be terminated back to the last day of the month for which premium was paid. In the event premiums are not received within the grace period and coverage is terminated, any claims incurred during the Grace Period will be denied. Furthermore, claims Incurred after the termination date will not be considered for payment.
5. **Modification of Premium Rates.** Premium rates will not be increased during the initial 12 months of coverage and not more than once in any 6-month period following the initial 12-month period, except for increases in the premium amount due to a change in age or geographic location of a covered *Subscriber* or an increase in the *Policy* benefit level. We will

notify *You* of any change at least [30] days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% or more is effective.

6. **Premium for Insurance Modifications.** Premiums shall be calculated as of the day such changes in coverage take effect.
7. **Cancellation or Termination.** We may cancel or terminate *Your* coverage under this *Certificate* with at least 60 days advance written notice delivered to *You*, or mailed to *Your* last known address. *You* may also cancel or terminate *Your* coverage at any time by providing at least 30 days advance written notice mailed to *Our* last known address. In the event of cancellation, *We* will promptly return the unearned portion of any premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
8. **Waiver of Premium When Totally Disabled.** *We* will waive premium for a *Subscriber* on the first of the month following the date *We* receive due written proof of the *Subscribers' Total Disability*. This provision is subject to all of the provisions of this *Certificate*, except as to the payment of premium. If a *Subscriber's Total Disability* ends and the *Subscriber* is still eligible for insurance under this *Certificate*, coverage will continue provided that premium is paid beginning with the first of the month following the *Subscriber's* return to active work.
9. **Premiums for Additions/Deletions.** In the event *We* do not receive the necessary written notice to delete a *Subscriber*, *We* will limit any refund of premiums to a period not to exceed [60 days] from the date *We* receive such written notice that the *Subscriber* should have been deleted. In our sole discretion, any claims incurred during the period for which premiums are refunded will not be covered under this insurance

In the event *We* do not receive the necessary written notice to add a *Subscriber*, *We* will limit the *Subscriber's Enrollment Date* to no more than [30 days] prior to the date *We* are notified in writing that the *Subscriber* should have been added; provided, *We* receive evidence that the premiums for such period were actually paid and received by *Us*. Any premiums paid for the period commencing on the date the *Subscriber* should have been added and the date *We* actually accept the *Subscriber* as a covered person under this insurance, at our sole discretion shall be refunded promptly and any claims incurred during this period will not be covered under this insurance.

SECTION 6 – CLAIMS PROVISIONS

UTILIZATION MANAGEMENT

Utilization Management is a proven strategy for containing health care costs. The goal of *utilization management* is to reduce the incidence of *medically unnecessary* and inappropriate *physician* care, surgical procedures, or *hospital* admissions through a pre-certification process.

This *Certificate* provides for the utilization of *Physicians* and health care professionals to determine the medical necessity and appropriateness of procedures and review claims submitted for reimbursement. All *Physicians* and *Hospitals* will be informed of this process as applicable. If questions arise regarding *Utilization Management* requirements, please call the utilization review provider. Questions will be answered professionally and confidentially by specially trained staff.

CLAIMS HANDLING

We will designate a Claims Administrator who shall be responsible for claims processing. Claim forms are to be submitted directly to the Claims Administrator.

Claim forms can be obtained from the Claims Administrator. If a doctor or other provider is submitting a claim where benefits have been assigned, he or she may use any standard or generally accepted claim form. The claim form must be completed and accompanied by an itemized bill that shows specific services, dates of service, and other information in detail.

If there is any question with regard to *Subscriber* eligibility, continuance of coverage, payment of a claim, or if there is a dispute with the denial of a claim or the amount paid, contact should first be made with the Claims Administrator and then with the Policyholder. *You* are allowed at least 60 days to request a review of the claim. *You* have the right to review pertinent documents affecting the acceptability of a claim and to submit comments in writing. The review of the claim is

normally made within 30 days after receipt of a request for review. An additional 30 days will be allowed if special circumstances require more time. A notice in writing will be sent before the expiration of the initial 30-day period if an extension is needed. The decision on a review will be sent in writing. It will include specific reasons for the decision and will refer to pertinent *Certificate* or legal provisions on which the decision was based.

FRAUDULENT CLAIMS

Filing a false or misleading claim for benefits is a FELONY and is punishable by a fine and/or imprisonment. *We* have the right, but not the duty, to prosecute any person or organization who *We* believe may have filed for and/or received benefits as a result of filing a false or misleading claim for benefits. *We* may also prosecute, at *Our* sole discretion, any individual who *We* believe may have aided or assisted in the filing of a false or misleading claim. If a claimant is later found to be guilty of filing a false or misleading claim, *We* shall be relieved of any unpaid benefits otherwise due under this *Certificate* and shall pursue re-payment from the *Subscriber* or to any other parties for amounts already paid as may be permissible by law.

CLAIM FORMS

Upon receipt of a notice of claim, *Our* Claims Administrator will furnish to *You* such forms as are usually furnished for filing proofs of loss. If the forms are not furnished within [fifteen (15)] working days after providing adequate notice, *You* shall be deemed to have complied with the requirement of this *Certificate* as to proof of loss upon submitting, within the time fixed in this *Certificate* for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which a claim is made. It is *your* responsibility to advise the Claims Administrator if the claim form is not received.

NOTICE OF CLAIM

Written notice of claim must be given to *Us* within [ninety (90)] days after the occurrence or commencement of any loss covered by this *Certificate* or as soon thereafter as is reasonably possible. Written notice given by or on behalf of *You* to *Our* Claims Administrator, with information sufficient to identify the claimant, shall be deemed notice to *Us*.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this *Certificate*, no misstatement made by any *Subscriber* in the application for this insurance shall be used to void this *Certificate* or to deny a claim for loss *Incurred*, as defined herein, commencing after the expiration of such two (2) year period.

TIME OF PAYMENT OF CLAIMS

All benefits payable under this *Certificate* will be payable immediately upon receipt of due written proof of such loss. Should *We* fail to pay the benefits payable under this *Certificate* upon receipt of due written proof of loss, *We* shall have 30 days thereafter within which to mail a letter or notice which states the reasons *We* may have for failing to pay the claim, either in whole or in part, and which also gives a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, *We* shall then have 30 days within which to process and either pay the claim or deny it, in whole or in part, stating the reasons *We* may have for denying such claim or any portion thereof. *We* shall pay interest as required by law on the benefits due under the terms of this *Certificate* for failure on *Our* part to comply with the requirements of this provision.

SUBROGATION

To the extent that benefits are provided or paid under the *Policy*, *We* shall be subrogated to all rights of recovery which any *Subscriber* may acquire against any other party for the recovery of the amount paid under the *Policy*, however *Our* right of subrogation is secondary to the right of the *Subscriber* to be fully compensated for his damages. The *Subscriber* agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action *We* may require to facilitate enforcement of *Our* right of subrogation. *We* agree to pay *Our* portion of the *Subscriber's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *We* recover any portion of the benefits paid under the *Policy* pursuant to *Our* right of subrogation.

RIGHT OF REIMBURSEMENT

To the extent that benefits are provided or paid under the *Policy* the *Subscriber* agrees that if a *Subscriber* fully recovers his damages from a third party, then he will reimburse *Us* the portion of the damages recovered for the expenses incurred by the *Subscriber* that were provided or paid by *Us*. *We* agree to pay *Our* portion of the *Subscriber's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *We* recover any portion of the benefits paid under the *Policy* pursuant to *Our* right of reimbursement.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the duplication or overpayment of benefits for eligible expenses *incurred*. It applies when *You* are also covered by any other *Certificate* or policies. When more than one coverage exists, one *Certificate* normally pays its benefits in full and the other *Certificate* pays a reduced benefit. *We* will always pay either benefits in full or a reduced amount which when added to the benefits payable by the other *Certificate* or policies, will not exceed 100% of **Allowable Expenses**. Only the amount paid by *Us* will be charged against *Your* maximums.

Allowable Expenses: The *usual, customary & reasonable* expenses for medical and/or dental care or treatment. Part of the expenses must be covered under at least one of the policies.

As Used in this Section 6, 'policy' or 'plan' shall mean:

- coverage under a statutory workers' compensation policy;
- this *Certificate* or the *Group Policy* to which it applies;
- any group, blanket or franchise insurance policy or contract;
- a group contractual prepayment or indemnity policy;
- a group Health Maintenance Organization (HMO) contract, whether group practice or individual practice association;
- medical benefits coverage in automobile policies, to the extent permitted by law;
- any individual medical policy or coverage.

If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

Primary Plan: When *Our* Plan is primary, *Our* benefits are determined before those of the other policy. The benefits of the other policy are not considered.

Secondary Plan: When *Our* Plan is secondary, *Our* benefits are determined after those of the other *policy*. *Our* benefits may be reduced because of the other policy's benefits.

The "order of benefit determination" rules state whether *Our* Plan is the Primary Plan or Secondary Plan as to another plan covering the *Subscriber*. When there are more than two Plans covering the person, *Our* Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan(s).

ORDER OF BENEFIT DETERMINATION"

Our Certificate will be primary in all cases except for the following:

1. when any coverage is available under the federal Social Security Act or similar law; or
2. when Medicare is primary, or
3. when the *Subscriber* qualifies for Workers' Compensation or any other similar statutory program.

Right to Receive and Release Needed Information - *We* may, at *our* sole discretion, give or receive any information that *We* need to underwrite, investigate and/or settle claims under this insurance. Any person having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions or nonmedical information about *your* family or *you* is authorized to release such information to *us* or *our* designee. This includes information related to substance use or abuse. Any medical practitioner, medical facility, pharmacy, the Medical Information Bureau (MIB), employer or insurance company that may have such information is authorized to release such information to *us* or *our* designee. *We* or *our* Claims

Administrator may also release this information about *your* family or *you* to the MIB or any insurer to which *you* have applied for coverage or to anyone else it deems necessary to investigate and/or settle a claim under this insurance.

SECTION 7 -- DEFINITIONS

Accident or Accidental Injury: The term "*Accident*" or "*Accidental Injury*" means an, unforeseen event, or series of events which results in *Bodily Injury*.

This event must meet all of the following:

- it must happen while *You* are covered under this Plan, and
- the *Bodily Injury* must result directly from the covered *Accident* and must be independent of an *Occupational Disease*, ordinary disease of life or bodily infirmity.
- It must be in "*Occupational Accident*"

"*Accident*" **does not** include any of the following:

- aggression in a fight, or
- suicide or attempted suicide, or
- an *Illness or Sickness* (see Definitions), or
- [*Cumulative Trauma*, unless specifically covered by this plan, or]
- [*Occupational Disease*, unless specifically covered by this plan, or]
- [*Hernia of any type*, unless specifically stated in the **Schedule** as covered].

Accident Medical Deductible: The term "*Accident Medical Deductible*" means a specified dollar amount of covered expenses which must be *Incurred* and paid by a *Subscriber* before any other covered expenses can be considered for payment under this *Certificate*.

Ambulatory Care Facility: The term "*Ambulatory Care Facility*" means a facility equipped to handle surgical procedures that require *hospital-type* facilities, but do not require *hospital confinement*. In order to qualify, an *ambulatory care facility* must:

- be established, equipped and operated for the performance of surgical procedures by *physicians* who are part of an organized medical staff; and
- have equipment and supplies not usually available to a *physician* outside a *hospital* including operating rooms, recovery room, diagnostic facilities, emergency equipment and full-time *nurses*; and
- have a written agreement with a nearby *hospital* to accept patients who develop complications and require *hospital confinement*.

Ambulatory Surgical Center: The term "*Ambulatory Surgical Center*" means an institution or facility, either free-standing or as part of a *Hospital* with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and from which he or she is discharged within a twenty-four (24) hour period.

An office maintained by a *Physician* for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an *Ambulatory Surgical Center*.

[Average Weekly Wage]: The term "*Average Weekly Wage*" means the *Subscriber's* net earnings as reported to the Internal Revenue Service on Form Schedule C for the twelve (12) calendar months immediately preceeding the date of the *Accident*, divided by 52. If the period of time worked is less than one year, we will take the average of the total consecutive weeks worked as an *Independent Contractor*. The *Average Weekly Wage* will in no event be considered to be less than [\$100, \$150, 250]. If a Schedule C is not reported to the Internal Revenue Service the *Average Weekly Wage* reverts to the Minimum Weekly Benefit of [\$100, \$150, \$250].

[A *Subscriber's* average weekly compensation shall be calculated at 75% of the Gross Settlements earned by the *Subscriber* and reported on Form 1099 for the twelve (12) calendar months immediately preceding the date of the *accident*, divided by 52 weeks. If the period of time worked is less than one full year, then the average of the total consecutive weeks

worked as an *independent contractor* will be used to establish the Gross Settlement amount and then adjusted by the 75% factor for offsetting expenses and operating costs incurred by the *independent contractor*. This *average weekly compensation* amount will then be used to calculate the benefit amount payable as defined in the **Schedule** section of this policy.]

Bodily Injury: The term "*Bodily Injury*" means an "*Occupational Accident*" resulting in physical injury to a *Subscriber* which occurs during the *Coverage Period* and while the *Subscriber* is under contract and arises solely out of and in the course of his/her occupation and duties as defined in the *Covered Contract* as an *Independent Contractor*.

Convalescent or Skilled Nursing Facility: The term "*Convalescent*" or "*Skilled Nursing Facility*" means an institution or distinct part thereof, operated pursuant to law and meets all of the following conditions:

- It is licensed to provide, and is engaged in providing on an *inpatient* basis, for persons convalescing from *injury*, nursing services rendered by a registered *nurse* (R.N.), a licensed practical *nurse* (L.P.N.), or a licensed vocational *nurse* (L.V.N.) under the direction of a registered *nurse* and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential activities or daily living; and
- Its services are provided for compensation from its patients and under the full-time supervision of a *physician* or registered *nurse*; and
- It provides 24-hours per day nursing services by licensed *nurses*, under the direction of a full-time registered *nurse*; and
- It has a Medical Director and/or has a *physician* who visits the facility and its patients on a regular basis; and
- It maintains a complete medical record on each patient, and
- It is not, other than incidentally, a place for rest, custodial or educational care, the care of mental disorders, the care and treatment of substance abuse, or a home for the aged; and
- It is approved and certified by *Medicare*.

This term shall also apply to expenses *Incurred* in an institution referring to itself as an *Extended Care Facility*, *Convalescent Care Facility*, *Nursing Home* or any such other similar nomenclature.

Convalescent Period: The term "*Convalescent Period*" means a period of time commencing with the date of confinement to a *Convalescent or Skilled Nursing Facility*. Such confinement must meet all of the following conditions:

- Such confinement must commence within fourteen (14) days of being discharged from a *hospital*; and
- Said *hospital confinement* must have been for a period of not less than three (3) consecutive days; and
- Both the *hospital* and *convalescent* confinements must have been for the care and treatment of the same covered injury.

A *Convalescent Period* will terminate when free of confinement in any and all institutions providing *hospital* or nursing care for a period of ninety (90) consecutive days. A new *Convalescent Period* shall not commence until the previous *Convalescent Period* has terminated.

Cosmetic Procedure: The term "*Cosmetic Procedure*" means a procedure performed solely for the improvement of *Your* appearance and not for the improvement or restoration of a bodily function.

Coverage Period: The term "*Coverage Period*" means a continuous period of time that begins on the *Subscriber's Enrollment Date* and continues until coverage terminates as per the terms and conditions of this *Certificate*. Such *benefit period* will terminate on the earliest of the following dates:

- the day any Maximum Benefit applicable to a *Subscriber* is paid; or
- the day a *Subscriber* cease to be covered under this *Certificate*.

Covered Contract: The term "*Covered Contract*" means a legal, written work agreement which meets state *Independent Contractor* requirements and definitions as further defined in the *Covered Activity Rider*.

Cumulative Trauma: The term "*Cumulative Trauma*" means an *injury* diagnosed by a *Physician* as occurring without *Accidental Bodily Injury* being the direct cause of loss. *Cumulative Trauma* includes *injury* caused by continual stress and

strain. Such *injury* may be causally related to a persons' job. Such *injury* may be due to repetitive traumatic acts. Hernia is not considered to be Cumulative Trauma.

Custodial Care: The term "*Custodial Care*" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a *Subscriber*, whether or not totally *disabled*, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision of medication which can normally be self-administered.

Durable Medical Equipment: The term "*Durable Medical Equipment*" means equipment which is:

- able to withstand repeated use;
- primarily and customarily used to serve a medical purpose; and
- not generally useful to another individual or an otherwise healthy individual.

Examples of *Durable Medical Equipment* include, but are not limited to: wheelchairs, ventilators, *hospital* type beds, etc. Examples of equipment which do not meet the definition of *Durable Medical Equipment* include, but are not limited to: humidifiers, safety bars or other similar apparatus that assist in the activities of daily living, and exercise bikes or equipment, orthopedic shoes or lifts, saunas, spas, hot tubs, etc.

Emergency Care: The term "*Emergency Care*" means those procedures or services due to *Accidental Injury* or an *Illness* that results from a covered *Accidental Injury* that requires immediate medical attention.

Experimental: The term "*Experimental*" means services and supplies which are *experimental* or investigational in nature, meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not generally recognized as accepted medical practice and includes any such services or supplies requiring Committee approval not granted at the time of service.

Home Health Care Agency: The term "*Home Health Care Agency*" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

- it is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing and other therapeutic services; and
- it has policies established by a professional clinical group associated with the agency or organization. This group must include at least one *Physician* and at least one Registered Nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a *Physician* or Registered Nurse; and
- it maintains complete medical records; and
- it has a full-time administrator.

Home Health Care Plan: The term "*Home Health Care Plan*" means a program for care and treatment established and approved by the Attending *Physician*, which provides for coordinated care in the home which is *medically necessary*.

Hospital: The term "*Hospital*" means an accredited institution which is approved as a *Hospital* by the Joint Commission of the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria;

- It is primarily engaged in providing, for compensation from its patients and on an *inpatient* basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of *physicians*. If primarily a facility for the treatment of mental and/or psychological conditions, or chemical dependency, such facility must have a bona fide arrangement by contract or otherwise with a *Hospital* to perform such surgical procedures as may be required;
- it continuously provides twenty-four (24) hours per day nursing services by Registered Nurses under the supervision of *Physicians*; and
- it is not, other than incidentally, a place for rest, the aged, a *nursing home*, a hotel or the like.

Hospital Confinement: The term "*Hospital Confinement*" means a stay as a registered bed patient in a *hospital* for 24 hours or longer. A "registered bed patient" is one assigned to a bed in any department of a *hospital* except the *outpatient* department, and who is charged for room and board. The stay must be recommended by a *physician* for a *medically necessary* purpose. The patient cannot leave the *hospital* during the stay.

Illness or Sickness: The terms "*Illness or Sickness*" means a bodily disorder, disease, physical *Illness* or psychiatric disorder. *Illness/Sickness* also includes Pregnancy.

Incurred: The term "*Incurred*" means the date on which care, treatment, services or supplies are rendered or supplied.

Incurred Expenses: The term "*Incurred Expenses*" means the cost of services and supplies rendered or supplied. Such expenses shall be considered to have been *Incurred* at the time or date the service or supply is actually provided.

Independent Contractor: The term "*Independent Contractor*" means a *Subscriber* who meets the specific legal definitions and requirements as set forth in the applicable State law for an *Independent Contractor*. The following criteria represent the minimum requirements for an *Independent Contractor*:

1. perform work under a formal written work agreement or contract defined as a *Covered Contract*, and
2. receives compensation reported under a Form 1099 for compensation and self-employment tax purposes, and
3. have responsibility for determining the time, means and method of performing the work required under a *Covered Contract*, and
4. cannot be an employee of the *Participant/Sponsor* or any scheduled Additional Insured parties covered under this *Certificate*.

A "*Covered Contract*" means a contract, work agreement or lease agreement which has been submitted to and approved by Us.

Injury: See "*Accident*", "*Accidental Injury*" or "*Occupational Accident*".

Inpatient: The term "*Inpatient*" means a person who is admitted to a *Hospital* and who is confined to bed for health care.

Insurance Company: means the insurance company identified on the **Schedule** as the underwriter of this insurance.

Medically Necessary: The term "*Medically Necessary*" means those medical services, supplies or treatment authorized by a *physician* to treat *Your Accidental Injury* which are:

- consistent with the symptoms or diagnosis; and
- appropriate and accepted according to good medical practice standards; and
- consistent with the most appropriate supply or level of service which can safely be provided to the patient.

Medicare: The term "*Medicare*" means all benefits under Part A and/or Part B of Title XVIII of the Social Security Act of 1965 as may be amended from time to time.

Nurse: The term "*Nurse*" means an individual who has received specialized nursing training and is authorized to use the designation "RN" Registered *Nurse*, "LPN" Licensed Practical *Nurse* or "LVN" Licensed Vocational *Nurse*, and who is duly licensed by the state or regulatory agency responsible for issuing such license in the appropriate jurisdiction.

Occupational Accident: The term "*Occupational Accident*" means an "*Accident*" resulting in Bodily Injury sustained within the time frame indicated in the **Schedule** and which meets all of the following criteria and stipulations:

- it must happen while *You* are engaged in the duties as defined in the *Covered Contract* with the *Participant/Sponsor*, and
- engaged in a covered activity as defined herein, and
- it must happen while *You* are covered under this plan, and
- the *Bodily Injury* must result directly from the *Accident* and be independent of any *Occupational Disease*, ordinary disease of life or bodily infirmity.

"*Occupational Accident*" **does not** include any of the following:

- aggression in a fight
- a sojourn or personal deviation

- suicide or attempted suicide
- *[Cumulative Trauma, unless specifically covered by this plan]*
- *[Occupational Disease, unless specifically covered by this plan]*
- *[Hernia of any type, unless specifically stated in the **Schedule** as covered.]*

Occupational Disease: The term "*Occupational Disease*" means an *Illness* arising out of a *Subscriber's* duties under a *Covered Contract* which causes damage or harm to the physical structure of the body. *Occupational Disease* does not include ordinary *Illnesses* of life to which the general public is exposed outside of the *Subscriber's* duties defined within a *Covered Contract* or a *Illness* resulting directly from an *Accident*.

Outpatient: The term "*Outpatient*" means a person who is not admitted as an *Inpatient* but who receives health care, services or supplies.

Physician: The term "*Physician*" means a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), chiropractor (D.C.), podiatrist (D.P.M.), dentist (D.D.S. or D.M.D.), optometrist (O.D.), psychologist (Ph.D.), licensed independent clinical social worker (L.I.C.S.W.), registered *nurse* clinical specialist (R.N.C.S.), any other licensed practitioner-including *nurse* practitioners, *physician* assistants, *nurse* midwives, *nurse* anesthetist. A *Physician* must be acting within the scope of their license. This definition does not include someone who is related to a *Subscriber* by blood, marriage or adoption or who is normally a member of *Your* household.

Policy: The term "*Policy*", also referred to as "*Group Policy*" means the contract between the *insurance company* and the *Policyholder* under which *Participants* can provide insurance benefits to *Subscribers*.

Participant or Sponsor: The term "*Participant or Sponsor*" means a person or organization named in **Item #3 of the Schedule** that applies for coverage under the *Group Policy*. A *Participant or Sponsor* must complete a Participation Agreement and a Participant/Sponsor Submission Form agreeing to all requirements and terms specified and approved by the *insurance company*.

Policyholder: The term "*Policyholder*" means the organization named in **Item #1 of the Schedule**. The *Policyholder* may request cancellation of the *Group Policy*, *negotiate terms and conditions*, *request changes in coverage or amounts of insurance* and *request termination of all Certificates*.

Policy Effective Date: The term "*Policy Effective Date*" means the date/time designated in writing by the *insurance company* for the *Policyholder's* insurance to begin.

Participant/Sponsor Effective Date: The term "*Participant/Sponsor Effective Date*" means the date/time designated in writing by the *insurance company* for the *Participant/Sponsor's* participation under the policy to begin.

Pre-admission Testing: The term "*Pre-admission Testing*" means the actual charges made by a *Hospital* for services rendered on an outpatient basis which are *medically necessary* prior to scheduled *inpatient* confinement at the same facility.

Pre-existing Conditions: The term "*Pre-existing Conditions*" means an illness or injury for which a covered *Subscriber*:

- incurred charges
- received medical treatment
- consulted a physician, or
- took prescribed drugs

within 12 months before he or she became insured under a given benefit section of this policy.

Prescription Drug: The term "*Prescription Drug*" means any drug, under applicable state law, that is dispensed only with a written prescription from a *physician* and has a label bearing the legend: "*Caution: Federal law prohibits the dispensing without a prescription*". It is also any mixed medicine with at least one ingredient bearing the above legend.

Prosthesis (or Appliance): The term "*Prosthesis*" means a device to replace natural body parts or limbs; "*Appliance*" means a device or instrument used to assist an infirmed person in ambulating (e.g., walker, cane, crutches) or which is used to remedy a chronic condition.

Rehabilitation Facility: The term "*Rehabilitation Facility*" means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more *Hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *Hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a *Rehabilitation Facility* for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such facility by the Joint Commission on the Accreditation of Health Care Organizations or the Joint Commission for the Accreditation of Rehabilitation Facilities or similar group or organization.

Sojourn/Personal Deviation: The terms "*Sojourn or Personal Deviation*" means any personal deviation that takes away or interferes with the dispatched activities of the *Participant/Sponsor*.

Sound Natural Tooth: The term "*Sound Natural Tooth*" means a tooth that has no fillings or cavities, or the fillings or cavities do not undermine the tooth cusps; the pulpal tissues are healthy and intact; and the periodontal tissue shows little or no signs of active or chronic inflammation.

Subscriber: The term "*Subscriber*" means a person or persons who are either: a) a bona fide member of the *Sponsor* - if the *Sponsor* is an association or b) an individual *Independent Contractor* of a *Participant/Sponsor* who has applied to be a *Participant* under the *Group Policy*. To be a *Subscriber*, a person must first:

- meet the eligibility requirements for coverage, and
- be *validly enrolled*, and
- be contracted with a *Participant* covered under the *Group Policy*.

A *Subscriber's* coverage will not start until a **Request for Insurance Form** is completed and signed and is approved by Us.

Subscriber's Enrollment Date: The term "*Subscriber's Enrollment Date*" means the date that written notice is given that the *Subscriber's* insurance begins.

Usual, Customary And Reasonable Fee (UC&R): The term "*Usual, Customary and Reasonable Fee*" means the lesser of:

- the *usual* fee - the charge most frequently made for the covered services or supplies by a *Physician* or *Hospital*;
- the *customary* fee - the charge made for covered services or supplies by those of similar professional standing in the same geographic area;
- the *reasonable* fee - the charge determined by considering the complexity involved, the degree of professional skill required and other pertinent factors, if (1) and (2) above cannot be easily determined.

Valid Enrollment: The term "*Valid Enrollment*" means coverage is validly in force only if the enrollment information supplied to the *Insurance Company* or its Administrator is correct. The only way coverage can be in force is if information provided regarding the *Subscriber* is accurate, complete, legible and signed. No one is authorized to waive this requirement without prior written consent from the *Insurance Company* or its Administration.

Valid and Collectible Insurance: (Applies when *Our* coverage is subject to the Coordination Of Benefits provision) The term "*Valid and Collectible Insurance*" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by any of the following plans covering *You*:

- for individuals in a group whether on an insured, self-insured, or uninsured basis, such as group, blanket or franchise insurance, prepayment plans or any other plan arranged through any school, employer, trustees, association, union or employee benefit association, including individual policies which are not exclusively health policies; and
- provided under government programs; and
- required or provided by any federal, state or local law, except Medicaid or Medicare, and
- workers' compensation or similar statutory coverage.

Waiting Period: The term "Waiting Period" means a period of time a *Subscriber* must be continuously disabled before benefits are payable.

We, Us, Our or Ours: The terms "We", "Us", "Our", or "Ours" refer to the *insurance company* underwriting this coverage.

You, Your and Yours: The terms "You", "Your" or "Yours" refer to the *Subscriber*.

SECTION 8 – UNIFORM PROVISIONS

1. **Entire Contract.** All forms and documents related to this *Certificate* are part of the entire contract between all of the parties involved. These forms and documents include:
 - all documents requested and accepted by the *Insurance Company*,
 - all *Policyholder* Agreements,
 - all *Policyholder* applications,
 - all Participation Agreements,
 - all Enrollment Forms, and
 - this *Certificate of Insurance* including its attached endorsements, riders and amendments.
2. **(a) Request for Insurance.** We will provide each person who wishes to become a *Subscriber* with a Request for Insurance Form (also referred to as an 'enrollment form') along with any other document(s) we require to start coverage. These documents must be submitted by each person to be insured and must be accurate, complete, legible and signed. The only way coverage can be in force is if the *Subscriber* accurately includes all information asked for on the Request for Insurance Form and/or Health Statement and any other documents which are requested and approved by *Us*.

(b) Misstatement of Age. If the wrong age of an *Subscriber* is given on the *Subscriber* Enrollment Form and the coverage or premium is affected by age, the coverage and/or premium will be adjusted accordingly. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverage or amount of benefits or both shall be adjusted in accordance with the *insured's* true age. Any such misstatements of age shall neither continue nor terminate insurance otherwise validly in force.

(c) Misstatement of Eligibility. We reserve the right to refund any premiums reported and paid to *Us* on any insured person who is found to not meet the *Certificate* definitions of a *Subscriber*. The inadvertent receipt of any such premiums will not obligate *Us* to any potential claims. Upon determination of such receipt, *We* will refund those specific premiums to *You* within a reasonable amount of time.

(d) Time Limit for Reporting Changes in Covered Subscribers. The *Participant/Sponsor* must report changes in covered *Subscribers* by the end of each week on forms approved by *Us* or *our* authorized representative. *We*, at our sole discretion, may not honor any changes not reported to *Us* within 60 days of the date of such change.
3. **Actions of Law.** No legal action may be brought to recover under this *Certificate* prior to 60 days after filing proof of loss. No such action may be brought after three (3) years from the time written proof of loss is required to be given.
4. **Workers' Compensation.** This *Certificate* and the benefits provided are not in lieu of, nor shall affect any requirements for coverage under any *Workers' Compensation* law or other similar law.

If a *Subscriber* is not subject to workers' compensation laws or is not eligible for workers' compensation benefits as an Independent Contractor and if coverage for *Occupational Injuries* is extended to a *Subscriber*, benefits under this insurance will be payable for any covered Accidental Injury.
5. **Benefits and Examination Determination.** Binding decisions regarding benefits covered and payable are made by *Us*. No benefits are payable for services, supplies or treatment that are not *medically necessary* and appropriate. In the course of *Pre-certification* and/or *Utilization Management*, *We* may require that a *Subscriber* be examined by a *physician* of *Our* choosing, at *Our* expense.

If a *subscriber* refuses, the claims in question may be denied.

6. Certificate Changes. This *Certificate* may be changed at any time by *Us*. It is not necessary to have the consent of the *Policyholder*, *Participants* or *Subscribers* before making such changes. *Certificate* changes are made by an amendment or rider, signed by an officer of the *Insurance Company* or their designee. No agent may change the *Certificate* in any way, shape or form.

We are not bound by any promise or statements made by any individual or agent which is not in this *Certificate* or approved in writing by *Us*.

7. Physical Exam and Autopsy. We shall have the right and opportunity to examine any *Subscriber* when and as often as We may reasonably require during the pendency of a claim hereunder. We shall have the right to access an autopsy report in case of death where it is not forbidden by law.

8. Inadvertent Error. At Our sole discretion, the failure of a *Participant/Sponsor* or *Subscriber* to transmit, report, pay premium or comply with any of the provisions of this *Certificate* when such failure is due to an inadvertent error or clerical mistake, will not prejudice the insurance of a *Subscriber*.

9. Conformity with State Statutes. If any provision of this *Certificate* is in conflict with the statutes of the state in which it is delivered or issued for delivery, the provision is automatically amended to meet minimum requirements of the statute.

10. Audit. You agree to keep records of information needed to compute premium. You agree to let *Us* or *Our* representative examine and audit all *Your* payroll, business records, and documents including ledgers, journals, registers, vouchers, contracts, dispatch logs, tax reports, disbursement records and programs for storage or retrieving data. We have the right to conduct audits during regular business hours while this *Certificate* is in force and within three (3) years after the final settlement of all claims under this *Certificate*.

11. Bankruptcy or Insolvency. Your bankruptcy or insolvency will not relieve *Us* from liability under this *Certificate*. However, *Our* liability will be the same had *Your* bankruptcy or insolvency not occurred.

12. Inspection. We have the right, but not the duty, to inspect *Your* operations and work places. Such inspections are not safety inspections. They relate only to the insurability of the work places and the premiums to be charged. We may give reports to *You* on the conditions found upon inspection. We do not undertake to provide for the health or safety of *Your* employees, *Independent Contractors* or the public. We do not warrant that *Your* work places are safe or healthful or that they comply with any law, regulation, code or standard.

13. Age Limit. Benefits payable under this *Certificate* shall only apply to covered *Subscribers* prior to attaining the Age Limit shown in the Schedule. If the *Subscriber* reaches the Age Limit during a coverage period, AD&D benefits shall be reduced based on the Reduction of Benefits Table outlined next in #14. **Benefits for Subscribers Over [Age 70].**

14. Benefits for Subscribers Over [Age 70]. Benefits provided by this *Certificate* can be extended to a *Subscriber* over the age of [70] on a "**Named**" basis only. The *Subscriber* must qualify for and be approved by the Administrator before this extension of benefits will apply. The *Subscriber* must submit a Request for Extended Benefits and supply any required underwriting information including, but not limited to, an Attending Physicians statement, if required. The Administrator will advise the *Named Subscriber* in writing of any approval or disapproval of any request for extensions of benefits.

Extended Benefits. The benefits extended to *Subscribers* over the [age of 70] shall consist of Accidental Death & Dismemberment, Accidental Disability—(limited to Temporary Total benefits for a maximum of two years) and Accident Medical benefits. **No benefits are provided for Permanent Total Disability.** Your premium when [age 70] or older is based on 100% of the coverage that would be in effect if *You* were [under age 70]. "AGE" as used above refers to *Your* age on *Your* most recent birthday, regardless of the actual time of birth.

Reduction of Benefits Table. The amount payable for any AD&D loss will be reduced when *You are* [age 70] or older. The AD&D amount payable will be reduced by the applicable percentage shown in the following table:

<u>AGE ON DATE OF ACCIDENT</u>	<u>AMOUNT OF REDUCTION</u>
[70 – 74]	[35%]
[75 – 79]	[55%]
[80 – 84]	[70%]
[85 and Older]	[85%]

15. **Assignment of Disability Benefits.** Payments for Disability may be assigned to a third party as indicated on an Assignment of Benefits Form provided by *US*. The form must be completed, signed and approved by *Us* and the third party before it will take effect. Benefits paid under this Assignment of Benefits Provision will be deducted from the total amount of benefits payable to the eligible *Subscriber*.

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Pan-American Life Insurance Company
New Orleans, Louisiana

AGGREGATE LIMIT RIDER

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

AGGREGATE LIMIT

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

The Schedule is amended to include an Aggregate Limit of: [\$100,000, \$200,000, \$300,000, \$500,000, \$600,000, \$1,000,000, \$2,000,000].

It is also agreed that Section 7 – Definitions is amended to include the following;

Aggregate Limit: The term “*Aggregate Limit*” means the most we will pay for multiple *Subscriber injuries* which are the direct result of one covered *accident*. The amount of the “*Aggregate Limit*” is listed above. If this amount is not enough to pay full benefits to each *Subscriber*, We will pay each one a reduced benefit based upon the proportion that the “*Aggregate Limit*” bears to the total benefits or the expected total benefits that would otherwise be paid. If the total benefits are unknown at the time, We will determine the total expected benefits for each person.

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date_____

Pan-American Life Insurance Company
New Orleans, Louisiana

SPECIAL RIDER #1

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

SPECIAL RIDER

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

[This space is used to describe unique activities of a specific account.]

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until is is signed by the Policyholder and countersigned below by Our Authorized Representative.

Policyholder _____

Date _____

Authorized Signature _____

Date _____

Pan-American Life Insurance Company
New Orleans, Louisiana

SPECIAL RIDER #1

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

SPECIAL RIDER

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

The Certificate is cancelled effective [April 2, 2012].

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date _____

Pan-American Life Insurance Company
New Orleans, Louisiana

CASUAL LABORER RIDER

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

CASUAL LABORER PROVISION

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

1. The Casual Laborer must not be an employee of either the Dispatcher, the moving and storage company, the home delivery company, the covered Subscriber or the Participant/Sponsor.
2. The Driver of the delivery vehicle is required to notify the Dispatcher immediately after an injury to a Casual Laborer has occurred. All injuries must be reported even if medical attention was not necessary. The Driver of the delivery vehicle is required to give the Dispatcher the following information:
 - The address of where the Casual Laborer was picked up, and
 - If the Casual Laborer was obtained from a labor pool – the name of the labor pool, and
 - The Casual Laborer's name, and
 - The details and circumstances surrounding the accident, and
 - The details of injuries sustained by all parties involved, and
 - The names of any person(s) contributing to, involved in or causing the accident, and
 - Any witness to the accident, and
 - The address of where the Casual Laborer is to be returned after the work is completed or after released from medical care.
3. [Benefits provided to a Casual Laborer for a covered Accidental Injury shall be consistent with the benefits provided to covered Subscribers.]
4. The Participant/Sponsor and Subscribers further warrants that they will take reasonable and necessary precautions in obtaining Independent Contractor Casual Laborers that are both physically and medically capable of performing the work required of them.
5. The Participant/Sponsor and Subscribers warrants that any safety devices, supplies or materials that are Normally provided or required will be provided to all Casual Laborers.
6. As used in this Rider, the term Casual Laborer means a temporary helper or laborer who [is picked up at or near a pre-determined delivery address]; is not an employee of the Dispatcher, the moving and storage company, the home delivery company, the covered Subscriber or the Participant/Sponsor; is used only to unload the contents of the delivery vehicle at a pre-determined delivery address.

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date_____

Pan-American Life Insurance Company
New Orleans, Louisiana

COVERED ACTIVITY RIDER- CASUAL LABORER

This RIDER is to be attached to and forms a part of the *Certificate* shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

Insurance under the *Certificate* is provided to covered *Subscribers* participating under the *Participant/Sponsor* shown above and while engaged in the Covered Activity as specified hereon.

CASUAL LABORER PROVISION

Coverage under the Occupational Accident Insurance applies only during the time period in which the Subscriber is performing services on behalf of the Participant/Sponsor and ceases to apply once those services are complete. Should the Subscriber elect to provide future services on behalf of the Participant/Sponsor, coverage would resume and then again cease once those future services were complete.

Coverage is applicable while *You* are loading and unloading trucks inside the premises of a location operated by the *Participant/Sponsor* pursuant to a *covered contract*. Coverage does not apply at any other time.

1. The Casual Laborer must not be an employee of the Participant/Sponsor.
2. The Casual Laborer has the duty to report all injuries even if medical attention was not necessary. The Lumper is required to give the Participant/Sponsor the following information:
 - The details and circumstances surrounding the accident, and
 - The details of injuries sustained by all parties involved, and
 - The names of any person(s) contributing to, involved in or causing the accident, and
 - Any witness to the accident, and
3. The Participant/Sponsor further warrants that it will take reasonable and necessary precautions in obtaining Independent Contractor Casual Laborers that are both physically and medically capable of performing the work required of them.
4. The Participant/Sponsor warrants that any safety devices, supplies or materials that are Normally provided or required will be provided to all Casual Laborers.
5. As used in this Rider, the term Casual Laborer means a temporary helper or laborer who is not an employee of the Participant/Sponsor. The Casual Laborer is used only to unload the contents of a vehicle inside of the Participant/Sponsor's location(s).

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated. This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date _____

PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana

CONTINGENT LIABILITY COVERAGE RIDER

The Schedule of the Certificate of Insurance to which this Rider is attached is amended to include the following item:

Item 16. Amounts of Contingent Liability Insurance:

- 16 a. Contingent Liability Coverage: [\$1,000,000, \$2,000,000] any one Covered Person/Subscriber
- 16 b. Employers' Liability: [\$100,000, \$500,000, \$1,000,000] per person per accident
[\$500,000, \$1,000,000] injury by disease each person
[\$100,000, \$500,000, \$1,000,000] injury by disease policy aggregate
- 16 c. Aggregate Limit: [\$1,000,000, \$2,000,000] any one Covered Person/Subscriber

The Certificate of Insurance to which this Rider is attached is amended to include the following Coverage Part:

CONTINGENT LIABILITY COVERAGE PART

THIS COVERAGE PART CONTAINS BOTH A SUNSET PROVISION FOR REPORTING CLAIMS AND A COMMUTATION PROVISION FOR SETTLING CLAIMS, PLEASE READ CAREFULLY.

In return for the payment of premium, **We** agree to provide this Contingent Liability **Coverage** to the Participant/Sponsor. **Coverage** is provided during the period listed in Item 4. of the Schedule.

Various provisions in this Coverage part restrict Coverage. This Coverage is contingent on the occurrence of specified events. A covered contingency will occur when the Participant/Sponsor receives notice of a claim for Occupational **Bodily Injury** by a **Subscriber** who is seeking to be deemed an employee of the Participant/Sponsor in order to claim **Workers' Compensation** benefits from the Participant/Sponsor within the applicable **Workers' Compensation** law. This Coverage Part, including any riders, endorsements, and amendments constitute the **Coverage** granted. **We** and You have agreed to all the terms contained therein.

Read the entire Coverage Part carefully to determine rights, duties and what is and is not covered.

SECTION 1 – DEFINITIONS

DEFINITIONS

- A. **Accident**, in this Coverage Part, means an event which:
- a. was unforeseen, unplanned and unexpected;
 - b. occurred at a specifically identifiable time and place;
 - c. occurred by sudden and abrupt cause or by chance;
 - d. resulted in physical injury to a **Subscriber**;
 - e. arose out of and in the course of a **Subscriber's** duties under a **Covered Contract**;
 - f. occurred during the **Coverage Period**

- B. **Bodily Injury** means an occupational accident resulting in physical Injury to a Subscriber which occurs during the coverage period and while the Subscriber is under contract and arises solely out of and in the course of their occupation and duties as defined in the covered contract.
- C. **Covered Contract** means a legal, written work or lease agreement that meets state independent contractor requirements and definitions as further defined in the Covered Activity Rider and has been submitted to and approved by Us.
- D. **Subscriber** means **Your** owner/operators and contract drivers; provided:
- they have a written **Covered Contract** with **You**;
 - they are covered under an occupational accident Coverage approved by **Us**.
 - their name is on file with **Us** or our administrator; and
 - they are not (prior to a claim under this **Coverage**) a statutory employee of yours or another **Subscriber**.
- E. **Legal Expenses** means expenses incurring in defending **You** against claims, proceedings and suits and amounts incurred as:
- premiums for bonds to release attachments and for appeal bonds;
 - litigation costs included in a judgment against **You**; and
 - interest on judgments as required by law until **We** offer the amount due under this insurance.
- F. **Occurrence** means an **Accident** or series of **Accidents** arising out of one event or incident.
- G. **State** means any **State** of the United States of America and the District of Columbia.
- H. **We, Us or Our** refer to Pan-American Life Insurance Company.
- I. **Worker's Compensation Law(s)** means the worker's compensation law of each **State**. It includes any amendments to that law which are in effect during the **Coverage Period**. It does not include non-occupational disability benefits.
- J. **You or Your** refer to the Participant/Sponsor shown in the Declaration.

SECTION 2 – GENERAL SECTION

GENERAL SECTION

A. Coverage

This **Coverage** includes, at its effective date, the **Coverage**, the Declaration and all endorsements and schedules listed. It is a contract of insurance between **You** and **Us**. The only agreements relating to this insurance are stated in this **Coverage**. The terms of this **Coverage** may not be changed or waived except by rider or endorsement issued by **Us** to be part of this **Coverage**.

B. The Coverage Period

The **Coverage Period** is shown in Item 4. of the Schedule. If this **Coverage** is cancelled, the **Coverage Period** will end at 12:01 A.M. on the cancellation date.

C. Who is Insured

In addition to the person(s) or organization(s) named in Item 3. of the Declaration, each of the following is also a Named Insured:

- If the Participant/Sponsor in Item 3. of the Declaration is an individual, then his spouse, but only with respect to the conduct of a business of which the Participant/Sponsor is the sole owner.

2. If the Participant/Sponsor in Item 3. of the Declaration is a partnership or joint venture, then the partners and their spouses or members of the joint venture but only with respect to the conduct of the partnership's or joint venture's business.
3. If the Participant/Sponsor in Item 3. of the Declaration is a corporation, then the directors, officers and stockholders of the corporation, but only with respect to the conduct of the corporation's business.

SECTION 3 – INSURING AGREEMENTS

INSURING AGREEMENTS

Coverage – Contract Liability

We will pay the benefit **You** are required to pay under the **Workers' Compensation** laws of any **State** because of an **Accident** resulting in **Bodily Injury** to a **Subscriber**; provided that:

1. It is determined by a court of law or the appropriate State regulatory authority that **You** are required to pay those benefits within [36] months after the date of the **Accident**, and
2. the **Accident** must take place during the **Coverage Period** shown in Item 4. of the Schedule.

We will defend any claim, proceeding or suit against **You** for claims payable under this **Coverage**. **We** have the right to investigate and settle these claims, proceedings or suits. **We** have no duty to defend or continue defending a claim, proceeding or suit after **We** have paid **Our** applicable Limit of Liability under this **Coverage**.

We will pay on **Your** behalf the benefits required of **You** by the **Workers' Compensation** Law of any **State** up to the **Limits of liability** shown above..

If **We** make any payments in excess of the benefits regularly provided by the Workers Compensation Law or of any **State** on **Your** behalf, **You** will reimburse **Us** promptly.

SECTION 4 – LIMIT OF LIABILITY

LIMIT OF LIABILITY

The Limits of Liability shown on Item 16 c. of the **Schedule** above is the most **We** will pay.

The Limits of Liability shown in Item 16 c. above of the **Schedule** is the most **We** will pay for all claims involving **Bodily Injury** covered under this **Coverage** to any one **Subscriber**.

The Limits of Liability shown in Item 16 b. above of the **Schedule** is the most **We** will pay for all Employers' Liability claims involving **Bodily Injury** covered under this **Coverage** to any one **Subscriber**.

Any payments made to a Subscriber under the Certificate of Insurance to which this policy is attached will be treated as a payment under this Coverage Part and reduce the limit of liability available.

Naming more than one Participant/Sponsor in Item 1. of the **Schedule** does not increase our Limit of Liability under this **Coverage**.

SECTION 5 – EXCLUSIONS

EXCLUSIONS

This **Coverage** does not apply to:

- A. [Claims which did not arise from or in connection with an Accident while under **Dispatch**;
- B. [Claims arising out of the promulgation of any statute, regulation, or rule, or the amendment of any existing statute, regulation, or rule, the effect of which is to make an **Owner-Operator** or **Contract Driver** **Your** employee for purposes of the Workers' Compensation law;]
- C. [Claims arising out of all causes of action other than the Workers' Compensation laws]
- D. [Claims for an intentionally self-inflicted **Bodily Injury** to a **Subscriber** while either sane or insane or **Bodily Injury** intentionally caused or intentionally aggravated by **You**;

- E. [Claims results from a **Subscriber's** participation in:
1. a riot or act of civil disturbance;
 2. a felony;
 3. a war, declared or undeclared;
 4. any act of war; or
 5. the service of the armed forces of any country or any civilian non-combatant unit serving with such forces;]
- F. [Claims for **Bodily Injury** if the **Subscriber** was legally intoxicated under the law of the **State** where the **Accident** occurred.]
- G. [Claims for **Bodily Injury** occurring while the **Subscriber** was under the influence of any chemical substance not lawfully available or consumed in accordance with the Controlled Substance Act in force at the time and location of the **Accident**.]
- H. [Claims for **Bodily Injury** occurring outside the United States of America, its territories or possessions and Canada, but this exclusion does not apply to a citizen or resident of the United States of America or Canada who is temporarily outside the United States of America, its territories or possessions or Canada at your direction and while in the course and scope of duties under a **Covered Contract** with **You**]
- I. [Claims brought by a similarly situated **Subscriber** after the issuance of an order by a state administrative or regulatory agency or board or a court of competent jurisdiction which has the effect of making all of **Your** similarly situated **Subscribers** employees for the purposes of workers' compensation insurance;]

SECTION 6 – PREMIUM

PREMIUM

The premium is determined by applying the monthly rate per person to the number of **Subscribers**.

Premium will be due on the first day of each month. **You** must provide **Us** a monthly report on the first day of each month for the entire term of this **Coverage**. The monthly report must indicate the name and social security number of each **Subscribers**. The monthly premium due is determined by applying the monthly rate per person to the total number of **Subscribers** on the monthly report.

We have the right to change the rates at which future premiums will be calculated on the first day of any month. **We** will notify **You** of any change at least 30 days before the premium due date on which the new rates are to be effective. **We** may only make one rate change during the **Coverage Period** shown in Item 4. of the Declaration.

A grace period of 31 days is allowed for payment of each monthly premium due after the first month unless this **Coverage** is cancelled on or before the first day of the month. The **Coverage** will continue in force during this grace period. If premium is not paid by the end of the grace period, coverage terminates at the end of the month for which premium was paid.

The premiums determined above are 100% earned. Should this **Coverage** be cancelled by either **You** or **Us** for any reason, all premiums are fully earned and no return premium will be due.

SECTION 7 – CLAIMS

CLAIMS

A. Duty to defend

We will defend **You** against any claim, proceeding or suit against **You** for **Bodily Injury** covered by this insurance. **We** have the right to investigate and settle any claim, proceeding or suit at **Our** discretion. **We** have a duty to defend a claim if **You** are not defended by a **Workers' Compensation** insurer. **We** have no duty to defend or continue defending after **We** have paid **Our** applicable Limit of Liability shown in Item 16 a. of the Declaration.

You shall cooperate fully with **Us** and assist **Us** in the investigation, settlement or defense of any claim, proceeding or suit and shall, upon **Our** request, supply:

1. the names and addresses of the injured **Subscriber(s)** and any witness(es);
2. all notices, demands and legal papers related to a **Bodily Injury** covered under this insurance; and
3. such other information as **We** may require.

B. Claim Reporting

You shall notify **Us** as soon as practicable in the event of a claim or a situation which may result in a claim. Such notice shall be sent to:

[XXXXXXXXXXXXX
XXXXXX XXXXXX,
Any town, MA 00112]

You agree not to voluntarily make payments, assume obligations or incur expense on any claim, proceeding or suit against **You** for **Bodily Injury** that may be covered by this insurance except at your own cost.

C. Subrogation – Recover From Others

We have **Your** rights to recover any payments. **We** may make recoveries under this insurance from anyone liable for **Bodily Injury** covered by this insurance. **You** will do everything necessary to protect those rights for **Us** and help **Us** enforce them. **You** agree to do nothing that would interfere with those rights after any **Bodily Injury**.

D. Sunset Clause

This **Coverage** applies in respect of incidents which occur during the **Coverage Period** stated in Item 4. of the Declaration provided that, and only in so far as, such incidents are reported to **Us** within thirty six (36) months of the end of the **Coverage Period** stated in Item 4 of the Schedule unless extended by a longer period due to the filing of a compensable claim under a state's Worker's Compensation law, which claim is not barred by a statute of limitations or similar statute under state's Worker's Compensation law.

E. Commutation

We have the right to commute all claims at any point after sixty (60) months from the end of the **Coverage Period**. All claims which are not finally settled will be eligible for commutation. An independent actuary or appraiser shall be appointed by mutual agreement between **You** and **Us**. The independent actuary or appraiser shall investigate, determine and capitalize the present value of such unsettled claims. **We** will share the expenses of the independent actuary or appraiser with **You** equally.

We will advise **You** in writing of **Our** intention to commute along with the name of **Our** chosen appraiser and if **You** fail to respond in writing within 90 days then **You** will be deemed to have consented to the same.

If **We** and **You** cannot then mutually agree to an independent actuary or appraiser, both **We** and **You** will appoint their own independent actuary or appraiser who will, in turn, appoint a third independent actuary or appraiser who will establish the present value of each claim(s). **We** and **You** will pay the expenses of their own independent actuary or appraiser and share the expenses of the third independent actuary or appraiser equally.

We will pay **You** the present value determined by the independent actuary or appraiser within 30 days from receipt of the independent actuary's or appraiser's report. Upon receipt of **Our** payment, **You** agree to release **Us** from any further liability under this **Coverage** for such claim(s).

If for any reason, **We** fail to make payment within thirty (30) days of receipt from the independent actuary or appraiser, then **We** will pay **You** interest at the rate of 5% per annum on the present value of such claim(s) from the date payment was due to the date of actual payment.

SECTION 8 – CONDITIONS

CONDITIONS

A. Agreement Upon Terms

Your acceptance of this **Coverage** means that **You** agree with **Us** that the statements in the Declaration are **Your** representations, that this **Coverage** is issued in reliance upon such representations, and this **Coverage** embodies all agreements between **You** and **Us**, or any of **Our** agents, relating to this insurance, and that **Your** full compliance with all terms of this **Coverage** is a condition to **Our** liability hereunder.

B. Assignment

Your rights or duties under this **Coverage** may not be assigned or transferred without **Our** written consent.

C. Bankruptcy or Insolvency

Your bankruptcy, insolvency or other financial deficiencies will not relieve **Us** from reimbursement obligations under this **Coverage**, provided, however, our reimbursement obligations will be the same as they would have been had your bankruptcy, insolvency or other financial deficiencies not occurred.

law, regulation, code or standard.

D. Other Insurance

If any other insurance, indemnity or reimbursement agreement exists protecting **You** for **Bodily Injury** to which this insurance applies, this insurance shall be excess of such other insurance, indemnity or reimbursement agreement. But this does not apply to any excess insurance, indemnity or reimbursement agreement specifically purchased by **You** to apply in excess of our Limit of Liability.

This Rider is not binding upon Us until countersigned below by Our Authorized Representative.

Authorized
Date_____

Signature

Pan-American Life Insurance Company

New Orleans, Louisiana

[COVERED ACTIVITY RIDER- COURIER OPERATION]

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

Insurance under the Certificate is provided to covered *Subscribers* participating under the Participant/Sponsor shown above and while engaged in the Covered Activity as specified hereon.

[COURIER OPERATION]

Coverage is applicable while *you* are performing the regular duties of an owner/operator courier driver, scheduled co-driver or scheduled contract driver as defined below while "under dispatch" pursuant to a *Covered Contract*.

"Owner/Operator" is a person who meets all of the following criteria:

- Be an *Independent Contractor* as defined by law, and
- Responsible for determining the time, means and method of performing the work, and
- Entered into a *Covered Contract* with the *Participating/Sponsor* for the leasing of the Owner/Operator's motor vehicle, and
- Compensated on a Form 1099 and not a Form W-2, and
- Do not own or control the *Participant/Sponsor*.

"Co-Driver" is a Person who meet s all the definitions of an "Owner/Operator" and:

- Co-owns a motor vehicle which is under a long term lease contract with the *Participant/Sponsor*, and
- Drives the motor vehicle as an Independent Contractor, as defined by the law.

"Contract Driver" is a driver who drives a motor vehicle, owned or leased by an Owner/Operator or the *Participant/Sponsor*. A Contract Driver cannot be an employee of the *Participant/Sponsor* or the Owner/Operator. The "Contract Driver" must meet all of the following criteria:

- Be an *Independent Contractor* as defined by law and
- Works under a *Covered Contract* that provides for possible financial loss or gain by the Contract Driver relative to the operation of the motor vehicle being utilized, and
- Responsible for determining the time, means and method of performing the work, and
- Compensated on a Form 1099 and not form Form W-2.

"Under Dispatch" is the period of time you [operate a motor vehicle as a courier for the *Participant/Sponsor*.] This includes all of the following:

- [In route to pick up a load,]

- [Picking up a load,]
- [In route to deliver a load,]
- [Unloading a load,]
- [In route to pick up another load,]
- [The waiting time for a load if *you* are not at home,]
- [Returning to a terminal or home after delivering a load, which ever occurs first, and]
- [Performing vehicle repair.]

[As referred to herein, '*motor vehicle*' does not include any of the following: motorized and non-motorized bicycles (2-wheels); motorized and non-motorized tricycles (3-wheels); motorized and non-motorized scooters; motorized and non-motorized skates and skateboards; snowmobiles; motorcycles; mopeds; ATV's (all terrain vehicles); and trucks or any vehicle longer than 16 feet.]

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date_____

Pan-American Life Insurance Company

New Orleans, Louisiana

[COVERED ACTIVITY RIDER- LIMOUSINE OPERATION]

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

Insurance under the Certificate is provided to covered *Subscribers* participating under the Participant/Sponsor shown above and while engaged in the Covered Activity as specified hereon.

[LIMOUSINE OPERATION]

Coverage is applicable while you are performing the regular duties of an owner/operator limousine driver, scheduled co-driver or scheduled contract driver as defined below while "under dispatch" pursuant to a *Covered Contract*.

"Owner/Operator" is a Person who meets all of the following criteria:

- Be an *Independent Contractor* as defined by law, and
- Responsible for determining the time, means and method of performing the work, and
- Entered into a *Covered Contract* with the *Participant/Sponsor* for the leasing of the Owner/Operator's limousine
- Compensated on a Form 1099 and not a Form W-2, and
- Do not own or control the *Participant/Sponsor*.

"Co-Driver" is a Person who meets all the definitions of an "Owner/Operator" and:

- Co-owns a motor vehicle which is under a long term lease contract with the *Participant/Sponsor*, and
- Drives the motor vehicle as an Independent Contractor, as defined by law.

"Contract Driver" is a driver who drives a motor vehicle owned or leased by an Owner/Operator or the *Participant/Sponsor*. A Contract Driver cannot be an employee of the *Participant/Sponsor* or the Owner/Operator. The "Contract Driver" must meet all of the following criteria:

- Be an *Independent Contractor* as defined by law, and
- Works under a *Covered Contract* that provides for possible financial loss or gain by the Contract Driver relative to the operation of the limousine being utilized
- Responsible for determining the time, means and method of performing the work, and
- Compensated on a Form 1099 and not a Form W-2.

"Under Dispatch" is the period of time you operate[a limousine for the *Participant/Sponsor*.] This includes all of the following:

- [In route to pick up a passenger,]
- [Delivering a passenger to their destination,]
- [In route to pick up another passenger,]

- [The waiting time for a passenger if you are not at home,]
- [Returning to a terminal or home after delivering a passenger, which ever occurs first, and]
- [Performing vehicle repair.]

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date_____

Pan-American Life Insurance Company

New Orleans, Louisiana

NON OCCUPATIONAL BENEFITS RIDER

This RIDER is to be attached to and forms a part of the Certificate Number shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant Sponsor #: [12345]

NON-OCCUPATIONAL BENEFITS

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended to include coverage for the Non-Occupational Benefits shown below, subject to the following terms, conditions and limits.

Accidental Death & Dismemberment Benefit	-	Principal Sum	[\$0, \$2,500, \$5,000, \$7,500, \$10,000, \$25,000, \$50,000, \$100,000]
---	---	---------------	---

Accident Medical/Dental Expense Benefit	-	Maximum Benefit	[\$0, \$2,500, \$5,000, \$7,500, \$10,000, \$25,000, \$50,000, \$100,000]
		Payment Period	[26, 52, 104 weeks]
		Deductible	[\$0.00, \$100, \$250, \$500]

Time Limit for Loss	-	[within 72 hours of the date of the event] [within 30 days of the date of the event] [within 60 days of the date of the event] [within 90 days of the date of the event]
----------------------------	---	---

Non-Occupational Accident is defined as an unforeseen event or series of events, which results in Bodily Injury within the time frame indicated in the Time Limit for Loss.

This event must meet all of the following:

1. It must happen while You are under Contract with the Participant Sponsor.
2. It must happen while You are covered under this Plan.
3. The Bodily Injury must result directly from the Accident and not be the result of any other cause.
4. It **cannot** happen while you are on duty or under dispatch for the Participant Sponsor.

"Non-Occupational Accident "does not include any of the following:

- [1. Aggression in a fight]
- [2. Hernia of any type]
- [3. Suicide or attempted suicide]
- [4. Cumulative Trauma]
- [5. Occupational Disease]

Applicability of Other Provisions

- 1. Non-Occupational Accident coverage will start when Your other coverage under the *Certificate* starts.
- 2. Non-Occupational Accident applies to [Classes 1, 2, 3, 4 & 5] as shown in the Certificate Schedule and shall not apply to Spouses and Lumpers.
- 3. Non-Occupational Accident coverage will stop at the same time your other coverage under the policy stops.
- 4. Except as stated above, any reference to "Occupational Accident" is changed to "Occupational and Non-Occupational Accident".

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said policy other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date_____

Pan-American Life Insurance Company
New Orleans, Louisiana

SPECIAL RIDER #1

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

SPECIAL RIDER

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

The Schedule (Page 2), Item 8 is amended to include the following:

	Covered	Not Covered
Class 6 – Passengers of Owner Operators or Employees	<u>X</u>	<u> </u>

Section 7 – Definitions (Page 15) is amended to include the following:

[Passenger: The term “*Passenger*” shall mean an individual over the age of ten (10), riding as a passenger, but not as a member of the crew or driver, who is neither an employee of the participating motor carrier nor one who is receiving remuneration or compensation of any kind for this activity. (Hitchhikers and Casual Laborers are not considered a passenger).]

The Schedule (Page 2), as pertaining to Passengers, is amended to include the following benefits:

Accidental Death & Dismemberment Benefit – Principal Sum: [\$25,000, \$50,000, \$100,000, \$250,000, \$500,000]

Accident Medical Expense Benefit – Maximum Benefit: [\$0, \$5,000, \$10,000, \$25,000, \$50,000, \$100,000]
Payment Period: [26, 52, 104 weeks]
Deductible (Each Person/Occurrence): [\$0.00, \$100, \$250, \$500]

All other terms remain unchanged.

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date _____

Pan-American Life Insurance Company
New Orleans, Louisiana

PRE-EXISTING CONDITION RIDER

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

PRE-EXISTING CONDITIONS BENEFIT

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

Exclusion [35] of Section 4 – Limitations and Exclusions is deleted.

It is also agreed that the Schedule, as pertaining to *pre-existing conditions*, is amended to include the following benefits only.

Accidental Death & Dismemberment Benefit - Principal Sum	[\$5,000, \$10,000, \$15,000, \$25,000, \$50,000, \$100,000]
---	---

Accident Medical/Dental Expense Benefit	- Maximum Benefit	[\$5,000, \$10,000, \$15,000, \$25,000, \$50,000, \$100,000]
--	-------------------	---

	- Payment Period	[26, 52, 104 weeks]
--	------------------	---------------------

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date _____

Pan-American Life Insurance Company
New Orleans, Louisiana

**[COVERED ACTIVITY RIDER- TRUCKING
OPERATION]**

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

Insurance under the Certificate is provided to covered *Subscribers* participating under the Participant/Sponsor shown above and while engaged in the Covered Activity as specified hereon.

[TRUCKING OPERATION]

Coverage is applicable while you are performing the regular duties of an owner/operator truck driver, scheduled co-driver or scheduled contract driver as defined below while "under dispatch" pursuant to a *Covered Contract*.

"Owner/Operator" is a Person who meets all of the following criteria:

- Be an *Independent Contractor* as defined by law, and
- Responsible for determining the time, means and method of performing the work, and
- Entered into a *Covered Contract* with the *Participant/Sponsor* for the leasing of the Owner/Operator's truck
- Compensated on a Form 1099 and not a Form W-2, and
- Do not own or control the *Participant/Sponsor*.

"Co-Driver" is a Person who meets all the definitions of an "Owner/Operator" and:

- Co-owns a motor vehicle which is under a long term lease contract with the *Participant/Sponsor*, and
- Drives the motor vehicle as an Independent Contractor, as defined by the law.

"Contract Driver" is a driver who drives a motor vehicle owned or leased by an Owner/Operator or the *Participant/Sponsor*. A Contract Driver cannot be an employee of the *Participant/Sponsor* or the Owner/Operator. The "Contract Driver" must meet all of the following criteria:

- Be an *Independent Contractor* as defined by law, and
- Works under a *Covered Contract* that provides for possible financial loss or gain by the Contract Driver relative to the operation of the truck being utilized
- Responsible for determining the time, means and method of performing the work, and
- Compensated on a Form 1099 and not a Form W-2.

"Under Dispatch" is the period of time you [operate a truck for the *Participant/Sponsor*.] This includes all of the following:

- [In route to pick up a load,]

- [Picking up a load,]
- [In route to deliver a load,]
- [Unloading a load,]
- [In route to pick up another load,]
- [The waiting time for a load if you are not at home,]
- [Returning to a terminal or home after delivering a load, which ever occurs first, and]
- [Performing truck repair.]

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date_____

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana
TRUCKERS BLANKET OCCUPATIONAL ACCIDENT SUBMISSION

ACCOUNT IDENTIFICATION

Legal Name: _____
[] Individual [] Corporation [] Limited Corp [] Partnership [] Other
Physical Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____
Telephone: _____ FAX: _____
Email Address: _____

AGENT IDENTIFICATION

Agency Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ FAX: _____
Contact Person: _____ E-mail: _____
Requested Effective Date: _____
Date Quote Needed: _____

DRIVER INFORMATION & COMMODITIES HAULED

Number of Owner Operators: _____ Number of Contract Drivers: _____ Number of Team Drivers: _____

List all commodities hauled by percent of total for the year:

_____ % _____ %
_____ % _____ %

Does the Account haul: ☐ Hazardous/Waste Material [] Logging [] Explosives
[] Flammables [] Refuse [] Radioactive Cargo

ACCOUNT INFORMATION: #Years in Business: _____

[Type of Carrier: [] Common [] Contract [] Private [] Other: _____ LTL % _____ Truckload % _____ Driver Load/Unload % _____
Method of Driver Compensation: [] Mileage [] Revenue [] Hourly [] Trip [] Other (details) _____
Radius of round-trip by percent: more than 500 miles _____% 499 to 200 miles _____% 199 to 50 miles _____% less than 50 miles _____%
Driver's average length of haul: _____ miles Driver's average duration of haul: _____ days
Type of equipment by percent of total: VAN _____% REFRIGERATED _____% FLATBED _____% TANKER _____% DUMP _____%
DOUBLE TRAILERS _____% OVERSIZE/OVERWEIGHT _____% OTHER _____% (Details _____)
Does Account allow passengers: YES [] NO [] (If YES, give details) _____
Backhaul policy is under the control of ACCOUNT [] or at the discretion of the DRIVER [] --- Check one and give details: _____

Are Drivers required to report daily: YES [] NO [] List Account Terminal Locations: _____

DRIVER DISTRIBUTION Give total number of Owner/Operators, Contract Drivers, Team Drivers to be insured by state of residence for the current policy year

Alabama _____	Idaho _____	Michigan _____	New York _____	Tennessee _____
Arizona _____	Illinois _____	Minnesota _____	North Carolina _____	Texas _____
Arkansas _____	Indiana _____	Mississippi _____	North Dakota _____	Utah _____
California _____	Iowa _____	Missouri _____	Ohio _____	Vermont _____
Colorado _____	Kansas _____	Montana _____	Oklahoma _____	Virginia _____
Connecticut _____	Kentucky _____	Nebraska _____	Oregon _____	Washington _____
Delaware _____	Louisiana _____	Nevada _____	Pennsylvania _____	West Virginia _____
Dist of Col _____	Maine _____	New Hampshire _____	Rhode Island _____	Wisconsin _____
Florida _____	Maryland _____	New Jersey _____	South Carolina _____	Wyoming _____
Georgia _____	Massachusetts _____	New Mexico _____	South Dakota _____	TOTAL _____

SAFETY INFORMATION

[Motor Carrier's ID#: _____ Motor Carrier's DOT #: _____ Motor Carrier's EIN#: _____]

Does the Account have a specified individual who's full-time duty is that of a Safety Director? YES [] NO [] (name: _____)

Does the Account have a current written safety/loss control program: YES [] NO [] - If Yes, please provide the following information:

Who Developed the program? Name: _____
Years of Experience: _____ When was the program initiated: _____ When was it last updated: _____

Does the safety/loss program address the following items:

Inspections of operations, conditions and vehicles to identify hazards?	YES [] NO []
Frequency of Training of owner operators in safe work practices?	YES [] NO []
Specific owner operator rules?	YES [] NO []

How often are safety meetings conducted: _____ Are Owner/Operators required to attend YES [] NO []

How often are Owner/Operator's MVRs reviewed: _____ What is minimum age: _____ yrs What is maximum age: _____ yrs.

What MVR violation would cause Owner/Operator's Lease Agreement to be "inactive"

OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

[Accidental Death and Dismemberment Benefit:

Principal Sum: \$100,000 _____ \$150,000 _____ \$250,000 _____ Other _____

Lump Sum or Survivors Benefit (Please circle one)

Accident Medical Benefit:

Maximum Benefit: \$300,000 _____ \$500,000 _____ \$1,000,000 _____ Other _____

Deductible: \$0 _____ \$100 _____ \$500 _____ Other _____

Incurral Period: 26 weeks _____ 52 weeks _____ 104 weeks _____ Other _____

Temporary Total Disability Benefit:

Percentage of Average Weekly Earnings: 66 2/3% _____ 70% _____ Other _____

Maximum Weekly Benefit: \$350 _____ \$400 _____ \$500 _____ Other _____

Waiting Period: 7 days _____ 14 days _____ Other _____

Benefit Period: 26 weeks _____ 52 weeks _____ 104 weeks _____ Other _____

Permanent Total Disability:

Percentage of Average Weekly Earnings: 66 2/3% _____ 70% _____ Other _____

Maximum Weekly Benefit: \$350 _____ \$400 _____ \$500 _____ Other _____

Waiting Period: 26 weeks _____ 52 weeks _____ 104 weeks _____ Other _____

Benefit Period: To age 65 _____ To age 70 _____

Combined Single Limit: \$300,000 _____ \$500,000 _____ \$1,000,000 _____ Other _____

NON-OCCUPATIONAL ACCIDENT COVERAGE REQUESTED

Accidental Death and Dismemberment:

Principal Sum: \$5,000 _____ \$10,000 _____ Other _____

Accident Medical Benefit:

Maximum Benefit: \$2,500 _____ \$5,000 _____ Other _____

Deductible: \$0 _____ \$100 _____ Other _____

Incurral Period: 26 weeks _____ 52 weeks _____ Other _____]

Please provide a rate indication for "If Any" Workers' Compensation coverage: YES [] NO []

PRIOR CARRIER AND LOSS INFORMATION

Who is the current carrier: _____ What is the Anniversary Date: _____

Please provide 5 years of currently valued loss information in the grid provided below.

Policy Term	Carrier	Type of Coverage	Rate	Losses	Premium	# of Drivers

Has the account ever had an Occupational Disease, Cumulative Trauma or Contingent Type claim? YES [] NO []

If Yes, please explain: _____

Has the Account been informed, and acknowledges:

1. Occupational Accident coverage is not Workers' Compensation Insurance YES [] NO []
2. Occupational Accident coverage does not eliminate the Applicant's responsibility to provide Workers' Compensation if required by applicable state law. YES [] NO []
3. It is the Accounts responsibility for collecting premiums from the Independent Contractors and submitting them to this insurer or its duly authorized agent. YES [] NO []
4. The Account and the Agent understands this form is submitted for underwriting consideration and does not bind any Agent, Carrier, or Administrator to coverage. YES [] NO []
5. Coverage can be approved and made effective only in writing from the Administrator. YES [] NO []

[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.]

Signature of Applicant/Account: _____ Date: _____

Signature of Producer:_____

Date:_____

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana

AMENDATORY ENDORSEMENT

ATTACHED TO AND MADE A PART OF **CERTIFICATE NO. B-OCCACC-TA-C (6/12)**

The Certificate to which this Amendatory Endorsement is attached, when issued in Arkansas, has the following changes:

A. The COVER PAGE is amended to include the following NOTICE:

Should you have any questions with your coverage, you should contact your [agent][producer] identified on the application;

or you may contact our policyholder service office at:

Pan-American Life Insurance Company
[601 Poydras, New Orleans, Louisiana 70130
(877) 569-3075]

Furthermore, you may also obtain assistance through the:

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (800) 852-5494 or (501) 371-2640

B. **SECTION 3 – BENEFIT PROVISIONS**, the following change is hereby made:

Under **Coverage C. ACCIDENTAL DISABILITY BENEFIT, Reduction in Disability Income Benefits**, is deleted in its entirety and replaced with the following:

The amount of Total Disability Income Benefits will be reduced by the amount of any Social Security benefits payable on account of such *disability*. This amount will include any benefits payable for dependents. Cost-of-living increases in Social Security payments effective after the correct Social Security benefit has been determined will not be used to reduce *Our* Disability Income Benefit.

C. **SECTION 5 – PREMIUM PROVISIONS**, the following change is hereby made:

Item #5 **Modification of Premium Rates**, is deleted and replaced with the following:

5. **Modification of Premium Rates.** Premium rates will not be increased more than once in any 12 month period, except for increases in the premium amount due to a change in age or geographic location of a covered *Subscriber* or an increase in the *Policy* benefit level. We will notify *You* of any change at least [30] days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% of more is effective.

D. **SECTION 6 – CLAIMS PROVISIONS**, the following changes are hereby made:

1. **Time Limit on Certain Defenses** is revised to include the following:

Statements made in the application or enrollment form are representations and not warranties.

2. **Coordination of Benefits** is revised to include the following:

We will not reduce the amount of the disability benefits payable to the *Subscriber* because of the existence of

other coverage unless the *Policy* provides a minimum amount payable of fifty dollars (\$50.00) per month.

3. **Recovery of Overpayments**, the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the *Subscriber's* name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

For the purpose of this provision, the following definition is added:

Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

E. **SECTION 8 – UNIFORM PROVISIONS**, the following changes are hereby made:

1. Item #6 **Certificate Changes**, is hereby deleted in its entirety and replaced with the following:

Certificate Changes. This *Certificate* may be changed at any time by *Us*. Except for reductions in benefits or increases in premium, it is not necessary to have the consent of the *Policyholder*, *Participants* or *Subscribers* before making such changes. *Certificate* changes are made by an amendment or rider, signed by an officer of the *Insurance Company* or their designee, for reductions in benefits or increases in premium and by the *Policyholder*. No agent may change the *Certificate* in any way, shape or form.

We are not bound by any promise or statements made by any individual or agent which is not in this *Certificate* or approved in writing by *Us*.

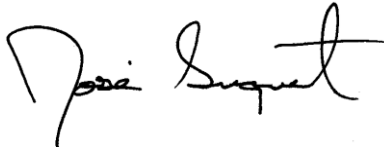
2. Item #7 **Physical Exam and Autopsy** the following is added:

The autopsy will be paid at *Our* expense.

This Amendatory Endorsement is endorsed and made part of the *Policy/Certificate* as of its Effective Date.

Except as amended above, the *Certificate* remains unchanged. All changes are subject to the terms and conditions of the *Policy*.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "David S. Sargent". The signature is fluid and cursive, with the first name "David" and last name "Sargent" clearly distinguishable.

President and Chief Executive Officer

PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana

(Hereafter called We, Us, Our or Ours)

BLANKET GROUP OCCUPATIONAL ACCIDENT MASTER INSURANCE POLICY

POLICYHOLDER:	[ABC Employer]
POLICY NUMBER:	[12345]
POLICY EFFECTIVE DATE:	[Effective Date]
ANNIVERSARY DATE:	[January 1, 2013]
POLICY TERM:	[Effective Date] to [Expiration Date]
STATE OF DELIVERY:	Louisiana
INSURING PROVISION:	The Company agrees, subject to all terms, provisions, conditions, exclusions and limitations of the Policy to pay the benefits provided by the Policy for any covered loss.
CONSIDERATION:	The Policy is issued in consideration of the statements and agreements contained in the Policyholder's/Participating Sponsor's application which is attached to and made a part of the Policy.
JURISDICTION:	The Policy is subject to the laws of the where the policy was issued.
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE:	The eligibility, enrollment and effective date requirements are described in the Certificate, the text of which is a part of this Policy. Eligible persons may apply for coverage under the Policy at any time during the term of the Policy. All such persons must meet the eligibility requirements in effect at the time of enrollment.
PAYMENT OF PREMIUMS:	All premiums are payable in advance for coverage under the Policy in accordance with Our premium rate schedule in effect on each premium due date. Premiums are payable to Us or our authorized agent.
GRACE PERIOD:	Unless the Policy is terminated, a grace period of [31 days] is allowed for payment of each premium due after the first premium. If any premium is not paid prior to the end of the grace period the coverage to which such premium applies will terminate as of the last day for which premium was paid.
PREMIUM CHANGES:	<p>We may change the premium rate schedule provided by the Policy on a class basis by giving the Policyholder written notice at least [30 days] prior to any such change and at least 45 days prior to any such change resulting in an increase of 20% or more.</p> <p>For a covered Subscriber, premium rates will not be increased during the initial 12 months of his or her coverage and not more than once in any 6-month period following the initial 12-month period, except for increases in the premium amount due to a change in age or geographic location of the covered Subscriber or an increase in the Policy benefit level.</p>
POLICY RENEWAL:	Except as provided in the Policy Termination provision below, the Policy is automatically renewed on each anniversary date.


POLICY TERMINATION:	This Policy may be terminated if We elect to discontinue offering this type of group insurance coverage or if We elect to discontinue all insurance coverage in accordance with applicable state and federal law. We will provide at least 60 days advance written notice in the event of cancellation.
POLICYHOLDER NOT OUR AGENT:	The Policyholder will not be considered our agent for any purpose under the Policy.
ENTIRE CONTRACT:	The Policy with any attached papers, the Certificate provisions, the Policyholder's application and the enrollment applications of the persons insured make up the entire contract. Statements made by the Policyholder or by persons insured are deemed to be representations and not warranties.
CHANGES:	Only an executive officer of Ours is authorized to change any part of the Policy. An endorsement signed by such officer and attached to the Policy will show any such change. No agent may change the Policy or waive any of its terms.
POLICY CONTESTABILITY:	The validity of the Policy will not be contested, except for non-payment of premiums, after it has been in force for [2 years] from the effective date. No statement made by any person insured relating to his insurability will be used in contesting the validity of the coverage with respect to which such statement was made after such coverage has been in force prior to the contest for a period of [2 years] during such insured person's lifetime. Also it may not be used unless it is contained in a written instrument signed by him and a copy of such instrument is or has been furnished to him or, in the event of the death or incapacity of the <u>personPrimary Insuredinsured</u> , to his beneficiary or his personal representative.
CERTIFICATES:	We will provide Certificates for delivery to each <u>Participant/SponsorPrimary Insured</u> . The Certificate will state the essential features of the coverage provided by the Policy and to whom benefits are payable. In the Certificate, the <u>SubscriberCertificate-holder</u> is referred to as You, Your and Yours.
NON-PARTICIPATING:	The Policy is issued on a non-participating basis. It does not share in Our surplus earnings.
WORKERS' COMPENSATION:	The Policy is not in lieu of and does not affect any requirement for coverage by Workers' Compensation.
CLERICAL ERROR:	Clerical error by Us or by a Participant/Sponsor in keeping any records will not: (a) invalidate coverage otherwise validly in force; or (b) continue coverage otherwise validly terminated.
CONFORMITY:	Any provision of the Policy that is in conflict with any law or regulation to which it is subject, is automatically amended to comply with the minimum requirements of such law or regulation.

THE REMAINDER OF THE POLICY CONSISTS OF THE CERTIFICATE AS ISSUED TO EACH PARTICIPANT/SPONSORPRIMARY INSURED. THE CERTIFICATE IS A PART OF THE GROUP POLICY. Riders, amendments and optional benefits, if any, adding to or changing the provisions of the Certificate are also made a part of the Policy.

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at end of the Policy Term unless the Policyholder and We agree in writing to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the premium due date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the state in which it is delivered.

Signed for Pan-American Life Insurance Company

A handwritten signature in black ink, reading "Jose Siquet". The signature is fluid and cursive, with a long horizontal stroke at the end. It is enclosed within red square brackets.

[Chairman of the Board
President and Chief Executive Officer]

State:	Arkansas	Filing Company:	Pan-American Life Insurance Company
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness		
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)		
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	11/01/2012
Comments:			
Attachment(s):			
Cert of Comp. with Rule 19 B-OCCACC.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	11/01/2012
Comments:	see form schedule tab for the application		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	11/01/2012
Bypass Reason:	na		

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter	Approved	11/01/2012
Comments:			
Attachment(s):			
ICC PAN-AM AUTH - OCCACC 2012.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved	11/01/2012
Comments:			
Attachment(s):			
Statement of Variables including special riders.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Professional Association of Independent Contractors (PAIC) bylaws and articles of incorporation, cklist	Approved	11/01/2012

SERFF Tracking #:	ICCI-128674182	State Tracking #:		Company Tracking #:	B-OCCACC-TA (6/12)
<hr/>					
State:	Arkansas	Filing Company:	Pan-American Life Insurance Company		
TOI/Sub-TOI:	H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness				
Product Name:	Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)				
Project Name/Number:	Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)				
<hr/>					
Comments:					
<hr/>					
Attachment(s):					
2011 PAIC - Balance Sheet at 12-31-2011.pdf					
2011 PAIC - PL Statement at 12-31-2011.pdf					
PAICBlue.pdf					
PAICGold.pdf					
PAIC (Professional Assoc of Independent Contactors) Bylaws.pdf					
PAIC (Professional Assoc of Independent Contractors) Articles of Incorporation.pdf					
Arkansas Association checklist.pdf					
Arkansas Member List.pdf					

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Pan-American Life Insurance Company

Form Number(s):

Blanket Group Occupational Accident Only Certificate B-OCCACC-TA-C (6/12)

Amendatory Endorsement – B-OCCACC-TA-AE-AR (6/12)

Aggregate Limit Rider – B-OCCACC-TA-R-AL (6/12)

Special Rider #1 – B-OCCACC-TA-R-AMED (6/12)

Special Rider #1 – B-OCCACC-TA-R-CAN (6/12)

Casual Laborer – B-OCCACC-TA-R-CL1 (6/12)

Covered Activity Rider – Casual Laborer – B-OCCACC-TA-R-CL2 (6/12)

Contingent Liability Coverage Rider – B-OCCACC-TA-R-CL (6/12)

Covered Activity Rider – Courier Operation – B-OCCACC-TA-R-CO (6/12)

Covered Activity Rider – Limousine Operation – B-OCCACC-TA-R-LIM (6/12)

Non-Occupational Benefit Rider – B-OCCACC-TA-R-NON (6/12)

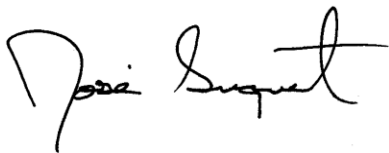
Special Rider #1 – B-OCCACC-TA-R-PAS (6/12)

Pre-Existing Condition Rider – B-OCCACC-TA-R-PE (6/12)

Covered Activity Rider – Trucking Operation – B-OCCACC-TA-R-TROP (6/12)

Group Application – B-OCCACC-TA-P-APP (6/12)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Jose Suquet

Name

President and CEO

Title

September 13, 2012

Date



June 1, 2012

NAIC Company Code: 67539

Re: Group Occupational Accident Only Policy, OCCACC-TA-P (6/12), et al

To: All State Insurance Departments

Pan-American Life Insurance Company of New Orleans, LA, hereby authorizes Insurance Compliance Consultants, Inc., to represent us in the submission of the above captioned forms and to negotiate with insurance departments for their approval.

Sincerely,

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, reading "José Suquet". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

José Suquet, President and Chief Executive Officer

STATEMENT OF VARIABLES

Purpose and Use of Forms

- Brackets around numbers or alphas in a listing and punctuation or words such as “and/or” in a listing will be included or deleted as needed in order to make the statement read correctly.
- Numeric variables within the Policy and related documents will always comply with the minimum statutory requirements of the state in which the Policy is delivered.
- All names, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.

Group Policy

POLICYHOLDER: - *Policyholder name will be included*

POLICY NUMBER: - *Policy Number will be included*

POLICY EFFECTIVE DATE: - *Policy Effective Date will be included*

ANNIVERSARY DATE: - *Anniversary Date will be included*

POLICY TERM: [Effective Date] to [Expiration Date] - *the effective date and expiration date will be included*

GRACE PERIOD: [30-31 days]

PREMIUM CHANGES: [30-60 days]

POLICY CONTESTABILITY: [1-5 years]

Officer's signature – *will be verified and included*

Group Certificate

Officer's signature – *will be verified and included*

Schedule

Policyholder – *the name of the Policyholder will be included*

Policy Number – *the Policy Number will be included*

Participant/Sponsor Number - *the Participant/Sponsor Number will be included*

Participant Sponsor - *the Participant/Sponsor name will be included*

Participant Sponsor's Effective Date - *the Participant/Sponsor Effective Date will be included*

Eligible Class – *either Covered or Not Covered will be included*

Covered Activity – *any Covered Activity will be included*

If the Accidental Death & Dismemberment Benefit is selected the following will be included and the selected amount will be included:

AD&D Principal Sum: [\$50,000, \$100,000, \$150,000, 250,000, \$300,000]

AD&D Maximum Any One Loss: [\$50,000, \$100,000, \$150,000, 250,000, \$300,000]

AD&D Reporting Period: [90-365] days from date of accident

Accidental Death Benefit: [90-365] days of the date of the Accident that caused the Injury, We will pay the Principal Sum as indicated below:

The following death benefit options will be listed and the selected death benefit option will be denoted with a check mark:

Installment Payment Option for Death Benefits: Yes ☒ No ☒

- ☐ Initial Death Benefit: [\$5,000, \$10,000, \$15,000, 25,000, \$30,000, \$50,000] Remaining balance is payable as a Survivor's Benefit @ [1%-10%] per month for [50-100] months or until satisfaction of the Survivor's Benefit; *whichever occurs first*.

- ☐ If No is checked above, the benefit for Accidental Death benefit will be paid in one Lump Sum.

Accidental Dismemberment Benefit: [180-365] days

Schedule of Accidental Death & Dismemberment Benefits for Loss of:

Principal Sum

Life.....	[15-100%]
Both Hands or Both Feet.....	[15-100%]
Sight of Both Eyes.....	[15-100%]
One Hand and One Foot.....	[15-100%]
One Hand and the Sight of One Eye.....	[15-100%]
One Foot and the Sight of One Eye.....	[15-100%]
Speech and Hearing in Both Ears.....	[15-100%]
One Hand or One Foot.....	[15-100%]
Speech.....	[15-100%]
The Sight of One Eye.....	[15-100%]
Hearing in One Ear.....	[15-100%]
Thumb and Index Finger of Same Hand	[15-100%]

Functional Loss of Use:

Principal Sum

Use of 4 Limbs	[15-100%]
Use of 3 Limbs	[15-100%]
Use of 2 Limbs	[15-100%]
Use of 1 Limb	[15-100%]

☐ **Accidental Disability Benefits:**

- **Disability Waiting Period:** [7, 14, 28] days
- **Retroactive Benefits:** No ☒ Yes ☒
- **Percent of Average Weekly Wages:** [66 2/3%, 70%]
- **Maximum Weekly Benefit:** [\$300, \$400, \$500, \$600, \$700]
- **Disability Reporting Period: Claims must be reported within:** [60-90] days from date of accident

Covered Not Covered Maximum Payment Period

- ☐ **Temporary Total Disability** ☒ ☒ up to [26, 52, 104, 156] weeks
- ☐ **Permanent Total Disability** ☒ ☒ up to Age [65, 70]

☐ **Accident Medical Expense Benefits:**

- **Maximum Medical Benefit Each Person Per Occurrence:** [\$100,000, \$250,000, \$300,000, \$500,000, 1,000,000, \$2,000,000]
- **Medical Deductible Each Person Per Occurrence:** [\$0.00, \$100, \$250, \$500]
- **Medical Reporting Period: Claims must be reported within:** [90-365] days from the date of the accident

- **Medical Incurral Period: Benefits are payable for:** [26, 52, 104, 156] weeks from the date of the accident
- **First Expenses: Must be incurred within:** [30-365] days from the date of the accident

Item 12. Additional Conditions and Limitations:

1. Premium Payment Mode - [Daily, Weekly, Monthly, Annual, Per Trip, Other]
2. Premium Calculation Mode - [15th of the Month, Other]
3. Age Limit (see Uniform Provisions for more details) - [AGE 65, 70]

Item 13. Supplemental Coverage Provided for:

	<u>Covered</u>	<u>Not Covered</u>
1. Occupational Disease	[X]	[X]
2. Cumulative Trauma	[X]	[X]
3. Sojourn/Personal Deviation	[X]	[X]
4. Hernia	[X]	[X]

Item 14. Maximum Limit Each Subscriber -- Per Occurrence

We will not pay more than [\$100,000, \$250,000, \$300,000, \$500,000, \$1,000,000, \$2,000,000] for all benefits combined (Accidental Death and Dismemberment, Accidental Disability and Accident Medical benefits combined) for each *Subscriber*.

Item 15. Forms, endorsements and riders attached to and made a part of this policy at issuance:
[Aggregate Limit, Trucking Operation, Non-Occupational, Pre-Existing Conditions, Casual Laborer Provision, Passenger Accident]

SECTION 3 – Benefit Provisions

Coverage A. ACCIDENTAL DEATH BENEFIT

If *You* suffer death within [90-365] days after a covered Accident, Accidental Death Benefits will be paid to *Your* eligible beneficiary(ies).

Installment Payment Option [1-10%] per month for a period of [50-100] months, [180-365] days [19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university];

Installment Payment Option

[If the Installment Payment Option is shown in the **Schedule** as YES then any death benefits will be paid in monthly installments. *Your* beneficiary may not elect payment in one sum after *Your* death.

The initial Death Benefit is shown in the **Schedule**. The remaining balance will be payable as a Survivor's Benefit in monthly installments of [1%-5%] per month for a period of [12-100] months after the initial payment has been made or until the satisfaction of the Survivor's Benefit; *whichever occurs first*.

If a *Subscriber* dies within [90-365] days after a covered Accident and before attaining the Age Limit and is survived by an eligible beneficiary, the Survivor's Benefit will be payable. This benefit will be paid in accordance with the terms, conditions, limitations and exclusions of this *Certificate*, and subject to the following:

- If a *Subscriber* is survived by a *spouse*, the *spouse* will receive a monthly benefit until he/she dies, remarries, enters into a common-law or otherwise meretricious relationship, or until the Maximum Benefit is paid, whichever occurs first;
- If the *spouse* is no longer eligible to receive this benefit, then any eligible *Dependent Child(ren)* will receive this benefit until no longer eligible, or until the Maximum Benefit has been paid, whichever comes first. Benefits to any *Dependent Child(ren)* ceases upon the child's attainment of age [19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university];
- If there are no eligible beneficiaries, no Survivor's benefit will be paid.

If the Installment Payment Option is shown in the **Schedule** as No then any death benefits will be paid in a Lump Sum.]

Coverage D.—ACCIDENT MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSE

2. for confinement in a *Convalescent* or *Skilled Nursing Facility*. However, such expenses are limited as follows:

- Charges will be considered only if confinement begins within [14-30] days after a *Hospital Confinement* of at [least three (3) consecutive days.]

SECTION 4 – LIMITATIONS AND EXCLUSIONS – the following limitations and exclusions may or may not be included at the option of the group policyholder:

[for, or in connection with, an *Occupational Disease* or *Cumulative Trauma* arising out of, or in the course of, any employment for wage or profit (unless specifically stated in the **Schedule** as 'covered');]

[for, or in connection with, an *Illness* or an *Injury* if the Subscriber is deemed to be an employee and covered under any Worker's Compensation or similar state or federal law;]

[for treatment, services or supplies received in a *Hospital* owned or operated by the United States Government;]

[for charges which *You* are not legally required to pay or for which no charge or payment would have been required if coverage was not in force;]

[which are in excess of *usual, customary and reasonable* charges; or which are determined to be inappropriate or not *medically necessary*;]

[for, or in connection with, *custodial care*, education or training;]

[for, or in connection with, reconstructive surgery or treatment; except as provided for herein;]

[as a result of war, declared or undeclared;]

[for eyeglasses, contact lenses and hearing aids, and examinations for their prescriptions and fitting including charges for surgical procedures for the correction of visual refractive problems (radial keratotomy), except for the replacement of eyeglasses, contact lenses or hearing aids which are damaged in a covered Accident;]

[for nursing, medical or surgical care or treatment rendered by a family member, including, but not limited to, a *spouse, child*, mother, father, brother, sister, parent of *spouse*, aunt, uncle, or son-in-law/daughter-in-law;]

[for, or in connection with dental services or supplies, except as provided for herein;]

[to the extent that *You* are reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any government sponsored program, including, but not limited to, *Medicare* or Social Security;]

[for any loss directly resulting from the commission of or attempt to commit a felony or directly resulting from being engaged in an illegal act or occupation;]

[for devices, equipment and supplies that are not durable medical equipment or prostheses;]

[for services paid, payable or required to be provided as Basic Repairs Benefits under any No-Fault Automobile Insurance Law. An uninsured or underinsured motorist will be considered *self-insured* for

bodily injury expenses. We will not be required to extend benefits which are required under any No-Fault Automobile Insurance Law;]

[for, or in connection with, *experimental* procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;]

[for *experimental drugs* or substances not approved by the Food & Drug Administration, or for drugs labeled: "*Caution: Limited by Federal Law to Investigational Use*";]

[for non-medical *hospital* expenses such as newspapers, guest trays, beauty shop services, cots, guest accommodations, admission kit, rental of telephones, radios, televisions or any other items solely for personal use or comfort;]

[for care, treatment, services, supplies, materials, and/or equipment which are not *medically necessary* or which are inappropriate for the diagnosis and related care/treatment of a covered *Accidental Injury*;]

[by any provider of medical services for the time spent traveling in the course of rendering medical care;]

[for the services of nutritionists, acupuncturists, massage therapists, herbalists, or other unlicensed allied health professionals;]

[for suicide, attempted suicide or self-inflicted *Bodily Injury* while sane or insane;]

[for failure to complete scheduled visits and charges for completion, copying or completion of any claim form, operative report or medical records;]

[for a *Bodily Injury* while a *Subscriber* is:

- Intoxicated (A *Subscriber* will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be *under the influence* of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the *Bodily Injury* occurs); or
- *Under the influence* of any narcotic, unless such narcotic was prescribed by a Physician and taken in accordance with the prescribed dosage.]

[for medical care or treatment received while incarcerated in a local, state or federal facility. Benefits as shown on the **Schedule** will be terminated as of the first day of incarceration;]

[for sickness, disease or bacterial infections;]

[for purposely self-inflicted *Injury* or any *Injury* resulting from a provoked attack;]

[for any *Bodily Injury* incurred while riding or driving in any kind of organized race for profit;]

[for any *Bodily Injury* incurred while travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,

- while being used for any test or experimental purpose; or
- while a *Subscriber* is operating, learning to operate or serving as a member of a the crew thereof; or
- while being operated by or for or under the direction of any military authority, other than transport type aircraft;]

[when skydiving, parasailing, bungee-jumping, or any similar activity: or]

[for prostatitis or hemorrhoids not directly related to an accident; or]

[for any amount of a covered claim that exceeds the Combined Single Limit. The Combined Single Limit is shown in the Schedule of Benefits; or]

[for "*Pre-existing Conditions*". The term "*Pre-existing Condition*" means an illness or injury for which a covered *Subscriber*:

- Incurred charges
- Received medical treatment
- Consulted a *physician*, or
- Took prescribed drugs

within 12 months before he or she became insured under a given benefit section of this policy.]

SECTION 5 – PREMIUM PROVISIONS

1. **Premium Remittance and Due Date.** [first or fifteenth] day of each month.

4. **Grace Period.** [31-45] day

5. **Modification of Premium Rates.** [30-90] days

9. **Premiums for Additions/Deletions.** [30-60 days]

SECTION 6 – CLAIM PROVISIONS

CLAIM FORMS [10-30]

NOTICE OF CLAIM [30-120]

SECTION 7 – Definitions

"Accident" **does not** include any of the following: *some or all of the following will be included at the option of the group policyholder*

- *[Cumulative Trauma, unless specifically covered by this plan, or]*
- *[Occupational Disease, unless specifically covered by this plan, or]*
- *[Hernia of any type, unless specifically stated in the **Schedule** as covered].*

Average Weekly Wage: [\$100, \$150, 250]. *[A Subscriber's average weekly compensation shall be calculated at 75% of the Gross Settlements earned by the Subscriber and reported on Form 1099 for the twelve (12) calendar months immediately preceding the date of the accident, divided by 52 weeks. If the period of time worked is less than one full year, then the average of the total consecutive weeks worked as an independent contractor will be used to establish the Gross Settlement amount and then adjusted by the 75% factor for offsetting expenses and operating costs incurred by the independent contractor. This average weekly compensation amount will then be used to calculate the benefit amount payable as defined in the **Schedule** section of this policy.] – may or may not be included at the option of the group policyholder*

"Occupational Accident" **does not** include any of the following: *some or all of the following will be included at the option of the group policyholder*

- *[Cumulative Trauma, unless specifically covered by this plan]*
- *[Occupational Disease, unless specifically covered by this plan]*
- *[Hernia of any type, unless specifically stated in the **Schedule** as covered.]*

SECTION 8 – UNIFORM PROVISIONS

13. **Age Limit.** [Age 70-75].

14. **Benefits for Subscribers Over [Age 70-75].**

<u>AGE ON DATE OF ACCIDENT</u>	<u>AMOUNT OF REDUCTION</u>
[70 – 74]	[35-85%]
[75 – 79]	[35-85%]
[80 – 84]	[35-85%]
[85 and Older]	[35-85%]

Special Rider # - form B-OCCACC-TA-R-CAN (6/12) – this rider will only amend the cancellation date of the Certificate.

Special Rider # - form B-OCCACC-TA-R-AMED (6/12) – this rider will amend the cancellation date, changes in exposure of benefits, name changes, effective dates and correction of misstatement or errors.

.

4:11 PM

04/04/12

Accrual Basis

Professional Association of Independent Contractors
Balance Sheet
As of December 31, 2011

	<u>Dec 31, 11</u>
ASSETS	
Current Assets	
Checking/Savings	
BOA - PAIC Checking - 1174	53.64
BOA - PAIC MM - 6873	5,444.44
Total Checking/Savings	<u>5,498.08</u>
Total Current Assets	<u>5,498.08</u>
TOTAL ASSETS	<u>5,498.08</u>
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Due to HPU	3,637.35
Due to LifeGuard	376.50
Total Other Current Liabilities	<u>4,013.85</u>
Total Current Liabilities	<u>4,013.85</u>
Total Liabilities	4,013.85
Equity	
Retained Earnings	561.73
Net Income	922.50
Total Equity	<u>1,484.23</u>
TOTAL LIABILITIES & EQUITY	<u>5,498.08</u>

4:12 PM
04/04/12
Accrual Basis

Professional Association of Independent Contractors

Profit & Loss

January through December 2011

	Jan - Dec 11
Ordinary Income/Expense	
Income	
Service Revenue	828,916.09
Service Revenue - Lloyds	9,888.45
Total Income	838,804.54
Gross Profit	838,804.54
Expense	
Administration Services	780,000.00
Association Benefits	9,586.00
Benefits Consulting	14,400.00
Business License & Fees	89.00
CASA - Driver Benefits	20,438.83
Marketing	682.36
Office Equipment	2,929.41
PAIC Benefits	2,298.00
Printing and Reproduction	1,949.96
Professional Fees	
Accounting Fees	1,325.00
Total Professional Fees	1,325.00
Tax	
State	94.00
Total Tax	94.00
Travel	
Airfare	2,422.10
Hotel	1,595.36
Taxi & Parking	228.00
Total Travel	4,245.46
Travel & Entertainment	
Meals	28.71
Total Travel & Entertainment	28.71
Total Expense	838,066.73
Net Ordinary Income	737.81
Other Income/Expense	
Other Income	
Interest Income	184.69
Total Other Income	184.69
Net Other Income	184.69
Net Income	922.50

Dear Prospective ITC Participant,

An overview of your PAIC member privileges is listed below. There are two types of benefits available to members: Those included in your membership and those that can be obtained through ITCP.

Independent Trucking Contractor Program (ITCP) is an endorsed package of voluntary benefits available for an additional premium. Select any combination that best suits your individual or family needs.

Benefits included in Blue Membership	Exclusive ITCP Insurance Options
<ul style="list-style-type: none">◆ Retail & Mail Order Pharmacy Card◆ Hotel Discounts Nationwide◆ Mail Order Vitamin Program◆ Hearing Aid Benefit◆ Car Rental Savings◆ Liberty Direct Diabetes Services◆◆◆◆◆ <p>This is NOT insurance.</p>	<ul style="list-style-type: none">◆ Two (2) Limited Medical Insurance Plans◆ Preferred Catastrophic◆ Short-Term Disability◆ Life Insurance◆ Accident Insurance◆ Dental Insurance◆ Critical Illness Protection <p><i>All insurance products are available on a guaranteed issue, contingent guaranteed issue basis or simplified issue basis.</i></p> <p>This is insurance.</p>

Additional information is below regarding each benefit listed above. ITCP representatives are available to assist, will review all benefits, and help you complete the necessary forms to activate insurance coverage.

Call Center: 1-877-517-8900

Thank you for your interest in ITCP.

The PAIC membership contains a money back guarantee:

Member shall receive a full refund of membership fees, excluding registration fee, if membership is cancelled before your first bill.

PAIC discounts are not insurance, they have negotiated discounts through certain providers for the benefits outlined.

The range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider

Medical Discount Plan Organization: AME, 2852 Johnson Ferry Rd., Marietta, GA. 30062

The Professional Association of Independent Contractors includes various discounts and services listed below for you/your family. Members can select ITCP Insurance Plans separately.

**Blue
Membership**
*

Hotel Discounts Nationwide: Discounts with various hotel chains accross the country:Clairon, Comfort Econo Lodge, Mainstay Suites, Rodeway, Sleep, Sleep Inn, and Quality hotels-ID#00133740 For Amerihost Inn, Howard Johnson, Knights Inn, Days Inn, Wingate, Ramada, Travelodge, Villager, ID#20285	X
Pharmacy Discounts**: Members save 17-55% at over 48,000 national and regional chains as well as independent pharmacies. Long-terms and maintenance prescriptions may be purchased through a mail order program for additional savings. go to www.findmyprovider.com , reference AME Benefits plan	X
Mail Order Vitamin Program Purchase a full array of Vitamins, Nutritional Supplements, Health & Beauty Aids, and non-prescription OTC Medicine at up to 70%. Call 1-800-645-1030 or go to www.puritanspride.com	X
Libery Direct Diabetes Services: Members save up to 15% off the wholesale price of supplies with our Mail Order Service. 1-800-263-8903	X
Car Rental Savings: Alamo, Avis, Budget, Hertz, and National	X
Hearing: FREE SCREENING. Receive a 15% discount on over 70 models of hearing aids at over 1200 Beltone locations nationwide. To locate a provider call 1-800-BELTOME or go to www.findmyprovider.com Present your member card and payment at the time of service.	X
#	X
# #	X
# # #	X
#	X
# #	X
This is NOT insurance and is NOT intended to be. For insurance see pages ahead. **Pharmacy discounts are not insurance, and Not intended as a substitute for insurance	

Dear Prospective ITC Participant,

An overview of your PAIC member privileges is listed below. There are two types of benefits available to members: Those included in your membership and those that can be obtained through ITCP.

Independent Trucking Contractor Program (ITCP) is an endorsed package of voluntary benefits available for an additional premium. Select any combination that best suits your individual or family needs.

Benefits included in Gold Membership	Exclusive ITCP Insurance Options
<ul style="list-style-type: none">◆ Retail & Mail Order Pharmacy Card◆ Hotel Discounts Nationwide◆ Mail Order Vitamin Program◆ Hearing Aid Benefit◆ Car Rental Savings◆ Liberty Direct Diabetes Services◆◆◆◆◆ <p>This is NOT insurance.</p>	<ul style="list-style-type: none">◆ Two (2) Limited Medical Insurance Plans◆ Preferred Catastrophic◆ Short-Term Disability◆ Life Insurance◆ Accident Insurance◆ Dental Insurance◆ Critical Illness Protection <p><i>All insurance products are available on a guaranteed issue, contingent guaranteed issue basis or simplified issue basis.</i></p> <p>This is insurance.</p>

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The Professional Association of Independent Contractors includes various discounts and services listed below for you/your family. Members can select ITCP Insurance Plans separately.

Gold Membership
*

Hotel Discounts Nationwide: Discounts with various hotel chains accross the country:Clairon, Comfort Econo Lodge, Mainstay Suites, Rodeway, Sleep, Sleep Inn, and Quality hotels-ID#00133740 For Amerihost Inn, Howard Johnson, Knights Inn, Days Inn, Wingate, Ramada, Travelodge, Villager, ID#20285	X
Pharmacy Discounts**: Members save 17-55% at over 48,000 national and regional chains as well as independent pharmacies. Long-terms and maintenance prescriptions may be purchased through a mail order program for additional savings. go to www.findmyprovider.com , reference AME Benefits plan	X
Mail Order Vitamin Program Purchase a full array of Vitamins, Nutritional Supplements, Health & Beauty Aids, and non-prescription OTC Medicine at up to 70%. Call 1-800-645-1030 or go to www.puritanspride.com	X
Libery Direct Diabetes Services: Members save up to 15% off the wholesale price of supplies with our Mail Order Service. 1-800-263-8903	X
Car Rental Savings: Alamo, Avis, Budget, Hertz, and National	X
Hearing: FREE SCREENING. Receive a 15% discount on over 70 models of hearing aids at over 1200 Beltone locations nationwide. To locate a provider call 1-800-BELTOME or go to www.findmyprovider.com Present your member card and payment at the time of service.	X
Vision Network: You will save 20-50% at over 11,000 optical centers nationwide.	X
# #	X
# # #	X
#	X
# #	X
This is NOT insurance and is NOT intended to be. For insurance see pages ahead. **Pharmacy discounts are not insurance, and Not intended as a substitute for insurance	

BYLAWS
OF
PROFESSIONAL ASSOCIATION OF INDEPENDENT CONTRACTORS, INC.

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PROFESSIONAL ASSOCIATION OF INDEPENDENT CONTRACTORS, INC.

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BYLAWS
OF
PROFESSIONAL ASSOCIATION OF INDEPENDENT CONTRACTORS, INC.

THESE BYLAWS of Professional Association of Independent Contractors, Inc., a Georgia nonprofit corporation, (the "Corporation") are hereby adopted by the Board of Directors of the Corporation as of the date set forth below.

ARTICLE I

OFFICES

Section 1. **PRINCIPAL OFFICE.** The principal office of the Corporation shall be located in the State of Georgia.

Section 2. **REGISTERED OFFICE AND AGENT.** The registered office of the Corporation shall be maintained at an address within the State designated by the Board of Directors. The Corporation shall have a registered agent whose address is identical with the address of such registered office, in accordance with the requirements of the Georgia Nonprofit Corporation Code.

Section 3. **OTHER OFFICES.** The Corporation may maintain such other offices, within or without the State, as the Board of Directors may designate or as the business of the Corporation may require.

ARTICLE II

PURPOSES AND GOVERNING INSTRUMENTS

Section 1. **NONPROFIT CORPORATION.** The Corporation shall be organized and operated as a nonprofit membership corporation under the provisions of the Georgia Nonprofit Corporation Code.

Section 2. The Corporation shall have all those general powers specified in sections 14-3-302 and 14-3-303 of the Georgia Nonprofit Code, including the power to do everything necessary, proper, advisable or convenient for the accomplishment of the purposes set forth herein, provided the same is not forbidden by the laws of the State of Georgia.

Section 3. **GOVERNING INSTRUMENTS.** The Corporation shall be governed by the Georgia Nonprofit Corporation Code, the Articles of Incorporation and these Bylaws.

ARTICLE III

MEMBERSHIP

Section 1. MEMBERSHIP. The Corporation shall have three (3) classes of membership: Class "A," Class "B" and Class "C".

Section 2. CLASS "A" MEMBERS. David King, Bob Lefebvre, and Phillip Williams shall be admitted as Class "A" Members of the Corporation. David King shall have the right to appoint and remove two (2) additional Class "A" Members in the sole discretion of Class "A" Member David King. David King initially appoints Nemat King and Joseph Zaffarese as Class "A" Members. Class "A" Members shall be entitled to vote on all Corporation matters pursuant to these By-Laws and allowable pursuant to the Georgia Nonprofit Code. Each Class "A" Member shall be entitled to cast one vote. Any matter requiring the vote of the Class "A" Members pursuant these By-Laws shall be based on the majority vote of all of the Class "A" Members entitled to vote. A Class "A" Member shall also have the right to serve on the Board of Directors for the Corporation and act as an officer of the Corporation. Class "A" Members shall have the right to resign at anytime from admission of a Class "A" Member of the Corporation. A Class "A" Member may be removed by majority vote of the Class "A" Members.

Section 3. CLASS "B" MEMBERS. All Class "B" Members shall consist of individuals who who purchase the Gold Membership Plan offered by the Corporation. Class "B" Members shall all be entitled to receive all of the benefits of the Gold Membership Plan offered by the Corporation, which may change from time to time. Class "B" Members shall have no voting rights or other rights except for those offered through the Gold Membership Plan. The membership held by a Class "B" Member shall automatically terminate thirty (30) days after a Class "B" Member fails to pay the dues required pursuant to the Gold Membership Plan.

Section 4. CLASS "C" MEMBERS. All Class "C" Members shall consist of individuals who who purchase the Blue Membership Plan offered by the Corporation. Class "C" Members shall all be entitled to receive all of the benefits of the Blue Membership Plan offered by the Corporation, which may change from time to time. Class "C" Members shall have no voting rights or other rights except for those offered through the Blue Membership Plan. The membership held by a Class "C" Member shall automatically terminate thirty (30) days after a Class "C" Member fails to pay the dues required pursuant to the Blue Membership Plan.

Section 5. ADDITIONAL CLASSES OF MEMBERS. Additional classes of members may be added upon the majority vote of the Board of Directors.

ARTICLE IV

BOARD OF DIRECTORS

Section 1. INITIAL BOARD OF DIRECTORS. The initial Board of Directors shall be David King, Bob Lefebvre, and Phillip Williams.

Section 2. POWERS OF DIRECTORS. The Board of Directors shall have the authority to manage the affairs and exercise the powers, privileges and franchises of the Corporation as they may deem expedient for the interest of the Corporation, subject to the terms of the Articles of Incorporation, Bylaws, and such policies and directions as may be prescribed from time to time by the Board of Directors. Directors need not be residents of the State of Georgia or be Members of the Corporation.

Section 3. ELECTION. The Corporation shall have three (3) directors. The Board of Directors shall be elected at each annual meeting of the Corporation by the majority vote of the Class "A"

Members and shall serve until their death, disability, removal or until their successors shall have been elected and qualified.

Section 4. VACANCIES. A vacancy occurring in the Board of Directors shall be filled by the affirmative vote of a majority of the remaining directors.

Section 5. DIRECTORS' MEETINGS. There shall be an annual meeting of the Board of Directors held on a date and at a place to be determined by the Board of Directors. Notice of each meeting of the Board of Directors shall be sent not less than ten (10) days prior to the date of the meeting. Notice of the time, date and place of each regular meeting shall be given by the Secretary either personally or by telephone or by regular mail to address of record for each director. Special meetings of the Board of Directors may be called at any time by the President or by any two directors upon two (2) days written notice to all of the directors, stating the time, date, place and purpose of such meetings. Notice of a meeting of the Board of Directors need not be given to any director who signs a waiver of notice either before or after the meeting. A director's attendance at or participation in a meeting waives any required notice to him of the meeting unless the director at the beginning of the meeting (or promptly upon his arrival) objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting. Directors may participate in and hold a meeting by means of telephone or similar communication whereby all persons participating in the meeting can hear each other. Participation in such a meeting shall constitute the presence in person at the meeting except where a director participates in the meeting for the express purpose of objecting to the transaction of any business on the grounds that a meeting is not lawfully called or convened.

Section 6. QUORUM AND VOTING. A majority of the directors shall constitute a quorum for the transaction of business. The act of a majority of the directors present, if a quorum exists, shall be the act of the Board of Directors.

Section 7. REMOVAL OF DIRECTORS. Any director may be removed with or without cause, at any time, by a majority vote of the directors at any special meeting called for that purpose or at the annual meeting.

Section 8. OFFICERS, SALARIES AND BONDS. The Board of Directors shall elect all officers of the Corporation and fix their compensation. The fact that any officer is a director shall not preclude him from receiving a salary or from voting upon the resolution providing salaries for himself or any other officer. The Board of Directors may or may not, in their discretion, require bonds from either or all of the officers and employees of the Corporation for the faithful performance of their duties and good conduct while in office.

Section 9. COMPENSATION OF DIRECTORS. Directors, as such, shall be entitled to receive such fees and expenses, if any, for attendance at each regular or special meeting of the Board and any adjournments thereof, as may be fixed from time to time by resolution of the Board, and such fees and expenses shall be payable even though an adjournment may result because of the absence of a quorum; provided, however, that nothing herein contained shall be construed to preclude any director from serving the Corporation in any other capacity and receiving compensation therefore.

Section 10. ACTION TAKEN WITHOUT MEETING. Any action required or permitted to be taken at a meeting of the directors may be taken without a meeting if a consent in writing setting forth the action so taken shall be signed by all of the directors.

Section 11. MANAGEMENT AGENT. The Board of Directors may employ for the Corporation a professional management agent, at a compensation established by the Board of Directors, to perform such duties and services as the Board of Directors shall authorize. The Board of Directors may delegate to the managing agent, subject to the Board's supervision, all of the powers granted to the Board of Directors by these By-Laws. An entity owned or controlled by one or more of the Class "A" members may be retained as the managing agent.

ARTICLE V

OFFICERS

Section 1. OFFICERS OF THE CORPORATION. The officers of the Corporation shall consist of a President and such other officers (including one or more Vice Presidents, a Secretary, and a Treasurer) as the Board of Directors may from time to time elect. Any two or more of said offices may be held by the same person simultaneously.

Section 2. ELECTION. The officers shall be elected annually by the Board of Directors, and each shall hold office until his death, disability, removal, or until his successor shall have been elected and qualified.

Section 3. REMOVAL. Any officer elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interest of the Corporation will be served thereby.

Section 4. POWERS AND DUTIES. The officers of the Corporation shall have the following duties, with all powers necessary to the performance thereof, and such other duties and powers as the Board of Directors may designate:

(a) President - The President shall be the chief executive officer, and shall, subject to the control of the Board of Directors, generally supervise and control all of the business and affairs of the Corporation and preside at all meetings of the officers. He or she shall sign all contracts executed in connection with the business and operation of the Corporation.

(b) Vice President - In the absence of the President or in the event of his inability to act, one or more of the Vice Presidents shall perform the duties of the President, and exercise all of the powers incidental thereto, as directed by the Board of Directors. The Vice President also shall perform such duties and exercise such powers as may be designated from time to time by the Board of Directors.

(c) Secretary - The Secretary shall keep the minutes and records of the Corporation, be responsible for the seal of the Corporation, and see that it is affixed to such papers as may require it, have charge of the membership roster and classification of each Member of the Corporation, see that all notices required by law are given and, attests to contracts executed in connection with the business and operation of the Corporation.

(d) Treasurer - The Treasurer shall receive and hold all funds and intangible property of the Corporation, and have charge of corporate finances generally. He or she shall be responsible for the preparation of all financial statements and returns required by law and shall sign all checks of the Corporation.

The above officers shall, in addition to the duties specifically prescribed above, have all duties and powers normally incidental to their respective offices as allowed under Georgia law. The Board of Directors may delegate to any officer any duties or authority hereinabove assigned to any officer, or may enlarge or restrict temporarily or permanently the duty and authority of any officer.

Section 5. BOND. The Board of Directors may, at its discretion, require any officer, agent or employee of the Corporation to give such bond for the faithful performance of their duties as may be deemed necessary or desirable.

Section 6. VACANCIES. All vacancies in any office shall be filled by the Board of Directors by a majority vote either at regular meetings or at a meeting specially called for that purpose.

ARTICLE VI

INDEMNIFICATION

Each director and officer of the Corporation shall be indemnified by the Corporation, to the fullest extent permitted by Article 8 of the Georgia Nonprofit Corporation Code (O.C.G.A. §14-3-850 *et. seq.*) or otherwise permitted by law, against any and all claims and liabilities to which he shall become subject by reason of serving in such capacity, or by reason of any action alleged to have been taken, omitted or neglected by him as a director or an officer. In addition, the Corporation shall reimburse such person for all legal expenses and other costs reasonably incurred by him in connection with any such claim or liability including the defense against such claim or liability. Notwithstanding the foregoing to the contrary, however, no such person shall be indemnified against, or be reimbursed for, any expense incurred in connection with any claim or liability arising out of his own willful misconduct or gross negligence.

ARTICLE VII

GENERAL PROVISIONS

Section 1. SEAL. The corporate seal of this Corporation shall be selected by the Board of Directors. An acceptable form of this seal is impressed on the margin hereof.

Section 2. FISCAL YEAR. Unless otherwise designated by the Board of Directors, the fiscal year of this Corporation shall end on December 31.

Section 3. CHARTER PROVISIONS. In case of any conflict arising at any time between the provisions of these Bylaws, as amended, and the provisions of the Articles of Incorporation, the provisions of the Articles of Incorporation shall govern and control.

Section 4. BOOKS AND RECORDS. The Corporation shall keep correct and complete books and records of the Corporation and its accounts and shall keep minutes of all proceedings of the Board of Directors. Corporate records shall be available for inspection by Members in accordance and as provided by the Georgia Nonprofit Corporation Code.

Section 5. NOTICES. Unless otherwise provided in these By-Laws, all notices, demands, bills, statements, or other communications under these By-Laws shall be in writing and shall be deemed to have been duly given if delivered personally or if sent by first class mail, first class postage prepaid, addressed to a Member at the address designated by the Member in his or her Membership Plan. Notice to the Corporation shall be sent to the President of the Corporation at his address, with a copy to the managing agent of the Corporation, if any, in the same manner as notice shall be sent to Members.

ARTICLE VII


ADOPTION AND AMENDMENT

Section 1. ADOPTION. These Bylaws shall become effective upon their adoption by a majority vote of the Class "A" Members of the Corporation, evidenced by the below signatures of the Board of Directors.

Section 2. AMENDMENT. These Bylaws may only be amended or modified by the majority vote of the Class "A" Members of the Corporation at any properly called annual or special meeting of the Board of Directors.

READ, APPROVED AND ADOPTED as of the 31 of May, 2009, pursuant to OCGA § 14-3-206 of the Georgia Nonprofit Corporation Code.

BOARD OF DIRECTORS:



David King



Bob Lefebvre

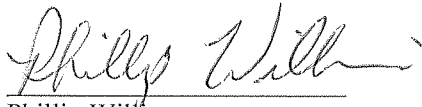
Phillip Williams

READ, APPROVED AND ADOPTED as of the 29 of May, 2009, pursuant to OCGA § 14-3-206 of the Georgia Nonprofit Corporation Code.

BOARD OF DIRECTORS:

David King

Bob Lefebvre

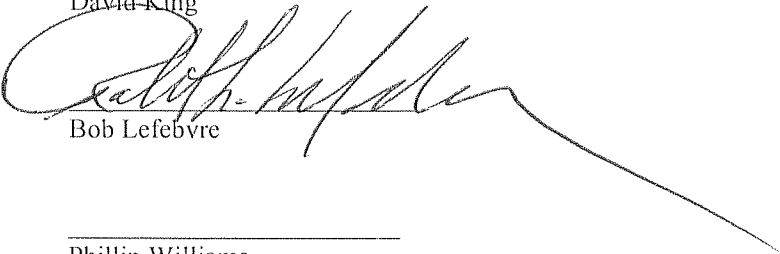


Phillip Williams

READ, APPROVED AND ADOPTED as of the ____ of May, 2009, pursuant to OCGA § 14-3-206 of the Georgia Nonprofit Corporation Code.

BOARD OF DIRECTORS:

David King



Bob Lefebvre

Phillip Williams

**AMENDMENT TO THE BYLAWS OF THE PROFESSIONAL ASSOCIATION
OF INDEPENDENT CONTRACTORS (PAIC).**

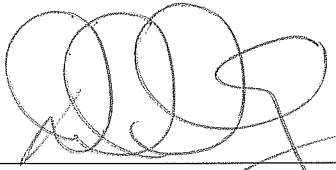
These Bylaws of The Professional Association of Independent Contractors were amended at a special meeting of the Board of Directors on March 23, 2011.

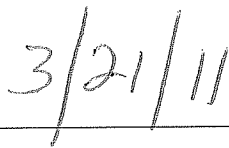
It was agreed that Article III would be amended to add a new class of members as shown below:

Section 5. CLASS "D" MEMBERS. All Class "D" Members shall consist of individuals who are self employed owners of small businesses and independently operated small businesses (Including Texas Nonsubscribers), and the employees of those small business owners. Class "D" Members shall all be entitled to receive all of the benefits of the Red Membership Plan offered by the Corporation, which may change from time to time. Class "D" Members shall have no voting rights or other rights except for those offered through the Red Membership Plan. The membership held by a Class "D" Member shall automatically terminate thirty (30) days after a Class "D" Member fails to pay the dues required pursuant to the Red Membership Plan.

READ, APPROVED AND ADOPTED as of the 21st of March, 2011.

FOR THE BOARD OF DIRECTORS



David D. King - Board Member

Date

STATE OF GEORGIA

Secretary of State

Corporations Division

315 West Tower

#2 Martin Luther King, Jr. Dr.

Atlanta, Georgia 30334-1530

CERTIFICATE OF RESTATED ARTICLES

I, **Karen C Handel**, the Secretary of State and the Corporations Commissioner of the State of Georgia, hereby certify under the seal of my office that

PROFESSIONAL ASSOCIATION OF INDEPENDENT CONTRACTORS, INC.

a Domestic Non-Profit Corporation

has amended and filed duly restated articles on 05/14/2009 in the Office of the Secretary of State and has paid the required fees as provided by Title 14 of the Official Code of Georgia Annotated. Attached hereto is a true and correct copy of said restated articles.

WITNESS my hand and official seal in the City of Atlanta
and the State of Georgia on May 14, 2009



A handwritten signature in cursive script, reading 'Karen C Handel'.

Karen C Handel
Secretary of State

**AMENDED AND RESTATED
ARTICLES OF INCORPORATION
OF
PROFESSIONAL ASSOCIATION OF INDEPENDENT CONTRACTORS, INC.**

Pursuant to O.C.G.A. § 14-2-1003 of the Georgia Business Corporation Code, Professional Association of Independent Contractors, Inc., a Georgia corporation, hereby submits the following Amended and Restated Articles of Incorporation:

ARTICLE 1. NAME. The name of the corporation is **PROFESSIONAL ASSOCIATION OF INDEPENDENT CONTRACTORS, INC.**

ARTICLE 2. DURATION. The corporation shall have perpetual duration.

ARTICLE 3. NON-PROFIT NATURE. The corporation is organized pursuant to the Georgia Nonprofit Corporation Code and shall not operate for profit or pecuniary gain.

ARTICLE 4. PURPOSES. The corporation is organized to engage in any and all lawful activity pursuant to Section 14-3-301.

ARTICLE 5. POWERS. The corporation shall have the general powers pursuant to Section 14-3-302.

ARTICLE 6. REGISTERED OFFICE; REGISTERED AGENT. The address of the initial registered office of the corporation shall be at 3405 Piedmont Road, NE, Suite 300, Atlanta, Georgia 30305, and the name of the initial registered agent at such address is Steven M. Winter.

ARTICLE 7. PRINCIPAL OFFICE. The mailing address of the initial principal office of the corporation is 3855 Shallowford Road, Suite 110, Marietta, Georgia 30062.

ARTICLE 8. ELECTION OF DIRECTORS. The directors of the corporation shall be elected or appointed at the time and in the manner as provided in the Bylaws of the corporation. The Board of Directors may delegate such operating authority to such companies, individuals, or committees as it, in its discretion, may determine.

State of Georgia
Expedite Amend/Restate 3 Page(s)



ARTICLE 9. MEMBERSHIP. The corporation shall be a membership corporation without certificates or shares of stock. There can be different classes of membership as determined by the Board of Directors. Each member of the corporation shall be entitled to vote as set forth in the Bylaws of the corporation.

ARTICLE 10. AMENDMENTS. These Articles may be amended as provided by the Georgia Nonprofit Corporation Code and the Bylaws of the corporation.

ARTICLE 11. DISSOLUTION. The corporation may be dissolved only as provided in the Bylaws, and by the laws of the State of Georgia.

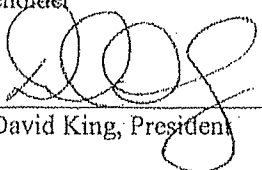
ARTICLE 12. LIABILITY OF DIRECTORS. Directors shall have no personal liability to the Corporation or its members for monetary damages for breach of the duty of care or other duty as a director except as otherwise provided under § 14-3-830 or § 14-3-860 through § 14-865 of the Georgia Nonprofit Corporation Code.

ARTICLE 13. INDEMNIFICATION. The corporation shall to the full extent permitted by Section 850 *et seq.* of the Georgia Nonprofit Corporation Code (O.C.G.A. § 14-3-850 *et seq.*), as such may be amended from time to time, indemnify all persons whom it may identify pursuant thereto.

This Amended and Restated Articles of Incorporation was duly adopted as of the 30 day of April, 2009 by the Board of Directors and the sole shareholder of the Corporation in accordance with the provisions of O.C.G.A. § 14-2-1003 of the Georgia Business Corporation Code.

IN WITNESS WHEREOF, Professional Association of Independent Contractors, Inc. has caused this Amended and Restated Articles of Incorporation to be executed by its President who is its sole director and sole shareholder as of the 30 day of April, 2009.

High Point Holdings, LLC
a Georgia limited liability company, its sole
shareholder


By: David King, President

PAIC\PAIC.LLC\DOCUMENTS\AMENDED AND RESTATED ARTICLES.DOC

RECEIVED
SECRETARY OF STATE
SOUTH GA OFFICE
09 MAY 14 AM 8:52

We have received your filing regarding the above named association/discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
Professional Association of Independent Contractors (PAIC)
3405 Piedmont Road NE, Suite 300
Atlanta, GA 30305
2. Is this group incorporated? If so, give state of incorporation. **Yes, Georgia**
3. Is there a current office in Arkansas? **No**
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details. **N/A per #3 above**
5. Are annual dues charged? If so, specify amount. **\$5 or \$10 depending on the plan**
6. What are the specific activities of the organization? **Provide benefits to independent contractors.**
7. What benefits are provided to the members in addition to insurance? **Rx Discounts, travel assistance benefits, access to services designed for Independent Contractor's.**
8. PLEASE ATTACH BROCHURES ON THE BENEFITS. **Attached are the requested brochures.**
9. What qualifies an individual for membership? **Must be an independent contractor and fill out an enrollment form.**
10. How are members recruited? If by mailing list, advise the source of this list. **Through Transportation companies**
11. Attach a copy of the organization by-laws. **The PAIC Bylaws and Articles of Incorporation are enclosed.**
12. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed - **Attached**
13. Please attach a copy of the organization's most recent financial statement. - **Attached**
14. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members? **No**

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

ARKANSAS MEMBER LIST

<u>Firstname</u>	<u>Lastname</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>
GREG W	ROSE	5443 N Ardmore	Prescott Valley	AR	86314
JIM	BARTLETT	800 Main Street	Conway	AR	72032
SHANNON	MODE	11 Wilcox Acres	Greenbrier	AR	72058
TIMOTHY	RANGLES	45 Aurora Lane	Vilonia	AR	72173
JIM	WATTS	10 Renae Drive	Greenbrier	AR	72058
GERALD	REES	2155 Highway 95	Hattieville	AR	72063
KEITH	CLARK	2411 Reech Street	Texarkena	AR	71854
KENDAL	PHILLIPS	81 Hwy 155 N	Casa	AR	72025
Willie	Logan	1237 S 10th Street	Blythville	AR	72315
Adam D.	Washington	2001 Reservoir Rd, Apt 45	Little Rock	AR	72227
Beverly C	West	754 Cook Rd	Donaldson	AR	71941
Bobby J	Gray	6603 Chateau Drive	Little Rock	AR	72209
Charles	Nelson	823 W 47th	N. Little Rock	AR	72118
David W.	Randolph	P.O. Box 17558	North Little Rock	AR	72117
Douglas	Avra	1914 Jennifer Dr	Little Rock	AR	72212
Dwayne A.	Priusich	120 East Conway St	Benton	AR	72015
Ellis	Eversole Jr	14536 W. Hwy 12	Gentry	AR	72734
Emma J.	Rice	403 N Springfield	Plummerville	AR	72127
Eric	Elliot	43 Warren Dr., #68	Little Rock	AR	72209
Erin C.	Tiemeyer	32 Flag Rd.	Little Rock	AR	72205
Gina A.	Beeson	1978 Slack St	Pea Ridge	AR	72751
Harvey L	Mobbs	13045 Red Oak Ln	Rogers	AR	72756
James Arthur	Black	123 Wints Dr.	Little Rock	AR	72206
Jean E.	Atkins	3025 Garniece Dr	Little Rock	AR	72206
Jena M.	Couch	PO Box 546	Elkins	AR	72727
Jenny L	Coggin	2921 Carley Place	Springdale	AR	72762
Jerry L	Carter Jr	11810 Pleasant Ridge Rd, Apt 804	Little Rock	AR	72223
Jesse	Shelley	40 Wofdale Rd	Farmington	AR	72730
Jimmie Lee	Fox	12 Danbury Lane	Jacksonville	AR	72076
John	Kerr	3100 Irby, #4111	Conway	AR	72034
Kevin	Smith	13 Crestwood Dr	Cabot	AR	72023
Laura Bonita	Vines	11 Cashin Lane	Bella Vista	AR	72715
Lynn D	Roberts	201 E. Appleby Rd, Lot #56	Fayetteville	AR	72703
Mark D.	Fitzpatrick	5012 Vaughn Rd	No. Little Rock	AR	72118
Paul	Blore	14028 Ruby Spring Rd	Farmington	AR	72730
Paul	Poindexter	P.O. Box 516	Morrilton	AR	72110
Paula J.	Melson	4003 Audry Ln	Hensley	AR	72065
Phil	Hull	103 Lakade Circle	Hot Springs	AR	71913
Richard	Taylor	501 N.37th Place	Rogers	AR	72756
Robert	Leonard	608 Neal St	Jacksonville	AR	72076
Robert B.	Buckalew	31 Ledge lawn Dr	Little Rock	AR	72212
Shirley A.	Reed	19719 Karen Drive	Little Rock	AR	72206
Steven	Armijo	2223 South Spring St.	Little Rock	AR	72206
Terry	Melson	4003 Audry Lane	Hensley	AR	72065
Terry L.	Reed	1902 Wooten Rd	North Ltle Rock	AR	72117
Thomas	Klyne	921 West Elm Blvd	Van Buren	AR	92956
Tina Marie	Martin	P O Box 304	Van Buren	AR	72957
Tony	Hannah	119 Vermont Place	Hot Springs	AR	71901
Vanessa L	Brickman	10 Canadian Cove	Maumelle	AR	72113
Vivian D	Norwood	818 North Filmore	Little Rock	AR	72205
William E.	Davidson Sr	6804 Lancaster Rd	Little Rock	AR	72209
William G.	Pruett	1601 Beresford Rd.	N. Little Rock	AR	72116
William R.	Bryant, Jr	10 Wright Circle	Jacksonville	AR	72076

State: Arkansas

Filing Company:

Pan-American Life Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.000 Health - Blanket Accident/Sickness

Product Name: Pan-Am Blanket Group Occupational Accident Only Policy B-OCCACC-TA (6/12)

Project Name/Number: Pan-Am Blanket Group Occupational Accident Only Policy/B-OCCACC-TA (6/12)

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/31/2012	Replaced 11/01/2012	Form	Amendatory Endorsement	11/01/2012	AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf (Superceded)
10/30/2012	Replaced 11/01/2012	Form	Amendatory Endorsement	10/31/2012	AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf (Superceded)
10/30/2012	Replaced 11/01/2012	Form	Amendatory Endorsement	10/30/2012	AR B-OCCACC-TA-AE-AR (6-12) 10-12-12.pdf (Superceded)
09/17/2012	Replaced 11/01/2012	Form	Amendatory Endorsement	10/30/2012	AR B-OCCACC-TA-AE-AR (6-12).pdf (Superceded)
09/06/2012	Replaced 11/01/2012	Form	Special Rider #1	10/30/2012	PALIC B-OCCACC-TA-R-AMED (6-12) Special Rider 8-2-12.pdf (Superceded)
09/06/2012	Replaced 11/01/2012	Form	Group Certificate	09/18/2012	PALIC B-OCCACC-TA-C (6-12) Trucking Certificate 8-2-12.pdf (Superceded)
09/06/2012	Replaced 11/01/2012	Supporting Document	Statement of Variability	10/01/2012	Statement of Variables.pdf (Superceded)

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana

AMENDATORY ENDORSEMENT

ATTACHED TO AND MADE A PART OF **CERTIFICATE NO. B-OCCACC-TA-C (6/12)**

The Certificate to which this Amendatory Endorsement is attached, when issued in Arkansas, has the following changes:

A. SECTION 3 – BENEFIT PROVISIONS, the following change is hereby made:

Under **Coverage C. ACCIDENTAL DISABILITY BENEFIT, Reduction in Disability Income Benefits**, is deleted in its entirety and replaced with the following:

The amount of Total Disability Income Benefits will be reduced by the amount of any Social Security benefits payable on account of such *disability*. This amount will include any benefits payable for dependents. Cost-of-living increases in Social Security payments effective after the correct Social Security benefit has been determined will not be used to reduce *Our* Disability Income Benefit.

B. SECTION 5 – PREMIUM PROVISIONS, the following change is hereby made:

Item #5 **Modification of Premium Rates**, is deleted and replaced with the following:

5. **Modification of Premium Rates.** Premium rates will not be increased more than once in any 12 month period, except for increases in the premium amount due to a change in age or geographic location of a covered *Subscriber* or an increase in the *Policy* benefit level. We will notify *You* of any change at least [30] days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% or more is effective.

C. SECTION 6 – CLAIMS PROVISIONS, the following changes are hereby made:

1. **Time Limit on Certain Defenses** is revised to include the following:

Statements made in the application or enrollment form are representations and not warranties.

2. **Coordination of Benefits** is revised to include the following:

We will not reduce the amount of the disability benefits payable to the *Subscriber* because of the existence of other coverage unless the *Policy* provides a minimum amount payable of fifty dollars (\$50.00) per month.

3. **Recovery of Overpayments**, the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the *Subscriber's* name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

For the purpose of this provision, the following definition is added:

Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

D. SECTION 8 – UNIFORM PROVISIONS, the following changes are hereby made:

1. Item #6 **Certificate Changes**, is hereby deleted in its entirety and replaced with the following:

Certificate Changes. This *Certificate* may be changed at any time by *Us*. Except for reductions in benefits or increases in premium, it is not necessary to have the consent of the *Policyholder*, *Participants* or *Subscribers* before making such changes. *Certificate* changes are made by an amendment or rider, signed by an officer of the *Insurance Company* or their designee, for reductions in benefits or increases in premium and by the *Policyholder*. No agent may change the *Certificate* in any way, shape or form.

We are not bound by any promise or statements made by any individual or agent which is not in this *Certificate* or approved in writing by *Us*.

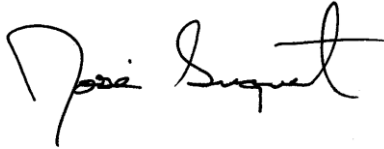
2. Item #7 **Physical Exam and Autopsy** the following is added:

The autopsy will be paid at *Our* expense.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Except as amended above, the Certificate remains unchanged. All changes are subject to the terms and conditions of the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Suquet". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

President and Chief Executive Officer

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana

AMENDATORY ENDORSEMENT

ATTACHED TO AND MADE A PART OF **CERTIFICATE NO. B-OCCACC-TA-C (6/12)**

The Certificate to which this Amendatory Endorsement is attached, when issued in Arkansas, has the following changes:

A. SECTION 3 – BENEFIT PROVISIONS, the following change is hereby made:

Under **Coverage C. ACCIDENTAL DISABILITY BENEFIT, Reduction in Disability Income Benefits**, is deleted in its entirety and replaced with the following:

The amount of Total Disability Income Benefits will be reduced by the amount of any Social Security benefits payable on account of such *disability*. This amount will include any benefits payable for dependents. Cost-of-living increases in Social Security payments effective after the correct Social Security benefit has been determined will not be used to reduce *Our* Disability Income Benefit.

B. SECTION 5 – PREMIUM PROVISIONS, the following change is hereby made:

Item #5 **Modification of Premium Rates**, is deleted and replaced with the following:

5. **Modification of Premium Rates.** Premium rates will not be increased more than once in any 12 month period, except for increases in the premium amount due to a change in age or geographic location of a covered *Subscriber* or an increase in the *Policy* benefit level. We will notify *You* of any change at least [30] days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% or more is effective.

C. SECTION 6 – CLAIMS PROVISIONS, the following changes are hereby made:

1. **Coordination of Benefits** is revised to include the following:

We will not reduce the amount of the disability benefits payable to the *Subscriber* because of the existence of other coverage unless the *Policy* provides a minimum amount payable of fifty dollars (\$50.00) per month.

2. **Recovery of Overpayments**, the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the *Subscriber's* name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

For the purpose of this provision, the following definition is added:

Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

D. SECTION 8 – UNIFORM PROVISIONS, the following changes are hereby made:

1. Item #6 **Certificate Changes**, is hereby deleted in its entirety and replaced with the following:

Certificate Changes. This *Certificate* may be changed at any time by *Us*. Except for reductions in benefits or increases in premium, it is not necessary to have the consent of the *Policyholder*, *Participants* or *Subscribers* before making such changes. *Certificate* changes are made by an amendment or rider, signed by an officer of the *Insurance Company* or their designee, for reductions in benefits or increases in premium and by the *Policyholder*. No agent may change the *Certificate* in any way, shape or form.

We are not bound by any promise or statements made by any individual or agent which is not in this *Certificate* or approved in writing by *Us*.

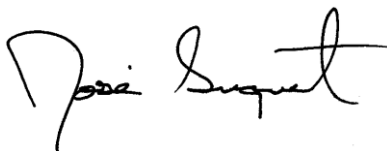
2. Item #7 **Physical Exam and Autopsy** the following is added:

The autopsy will be paid at *Our* expense.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Except as amended above, the Certificate remains unchanged. All changes are subject to the terms and conditions of the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Siquet". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

President and Chief Executive Officer

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana

AMENDATORY ENDORSEMENT

ATTACHED TO AND MADE A PART OF **CERTIFICATE NO. B-OCCACC-TA-C (6/12)**

The Certificate to which this Amendatory Endorsement is attached, when issued in Arkansas, has the following changes:

A. SECTION 3 – BENEFIT PROVISIONS, the following change is hereby made:

Under **Coverage C. ACCIDENTAL DISABILITY BENEFIT, Reduction in Disability Income Benefits**, the following is added:

The amount of any such reduction shall not be increased with any increase in the level of Social Security benefits payable that becomes effective after a claim commences.

B. SECTION 5 – PREMIUM PROVISIONS, the following change is hereby made:

Item #5 **Modification of Premium Rates**, is deleted and replaced with the following:

5. **Modification of Premium Rates.** Premium rates will not be increased more than once in any 12 month period, except for increases in the premium amount due to a change in age or geographic location of a covered *Subscriber* or an increase in the *Policy* benefit level. We will notify *You* of any change at least [30] days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% of more is effective.

C. SECTION 6 – CLAIMS PROVISIONS, the following changes are hereby made:

1. **Fraudulent Claims** is revised to include the following:

Statements made in the application or enrollment form are representations and not warranties.

2. **Coordination of Benefits** is revised to include the following:

We will not reduce the amount of the disability benefits payable to the *Subscriber* to the extent of and because of the existence of other such coverage unless the *Policy* provides a minimum amount payable, regardless of the reduction, of fifty dollars (\$50.00) per month.

3. **Recovery of Overpayments**, the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the *Subscriber's* name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

For the purpose of this provision, the following definition is added:

Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

D. SECTION 8 – UNIFORM PROVISIONS, the following changes are hereby made:

1. Item #2 (c) **Misstatement of Eligibility**, the following is added:

Statements made in the application or enrollment form are representations and not warranties.

2. Item #5 **Benefits and Determination** is deleted in its entirety.

3. Item #6 **Certificate Changes**, the following is added:

Any reduction in benefits or any increase in premium will be made on a form signed by the Policyholder.

4. Item #7 **Physical Exam and Autopsy** the following is added:

The autopsy will be paid at *Our* expense.

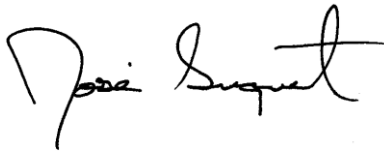
5. Item #10 **Audit** is deleted in its entirety.

6. Item #12 **Inspection** is deleted in its entirety.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Except as amended above, the Certificate remains unchanged. All changes are subject to the terms and conditions of the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Siquet". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

President and Chief Executive Officer

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana

AMENDATORY ENDORSEMENT

ATTACHED TO AND MADE A PART OF **CERTIFICATE NO. B-OCCACC-TA-C (6/12)**

The Certificate to which this Amendatory Endorsement is attached, when issued in Arkansas, has the following changes:

SECTION 6 – CLAIMS PROVISIONS, the following is added:

Recovery of Overpayments, the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the *Subscriber's* name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

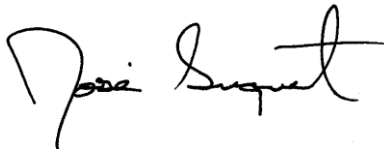
For the purpose of this provision, the following definition is added:

Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Except as amended above, the Certificate remains unchanged. All changes are subject to the terms and conditions of the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Siquet". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

President and Chief Executive Officer

Pan-American Life Insurance Company
New Orleans, Louisiana

SPECIAL RIDER #1

This RIDER is to be attached to and forms a part of the Certificate shown below issued by Pan-American Life Insurance Company, New Orleans, Louisiana to the Policyholder shown below.

Effective Date: [mm/dd/yyyy]

Policy Number: [12345]

Policyholder: [Professional Association of Independent Contractors]

Participant/Sponsor: [ABC Company]

Participant/Sponsor #: [12345]

SPECIAL RIDER

It is hereby understood and agreed that the Certificate to which this Rider is attached is amended as follows:

[This space is used to describe unique activities of a specific account.]

Nothing in this Rider shall be held to alter, vary or affect any of the terms, provisions and conditions of said *Certificate* other than as above stated.

This Rider is not binding upon *Us* until countersigned below by Our Authorized Representative.

Authorized Signature _____

Date _____

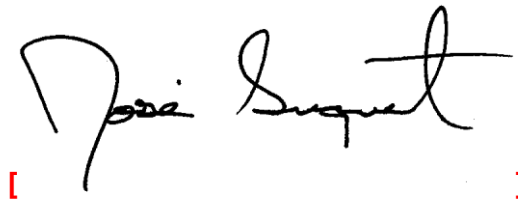
PAN-AMERICAN LIFE INSURANCE COMPANY

New Orleans, Louisiana
(Hereafter called We, Us, Our or Ours)

BLANKET GROUP OCCUPATIONAL ACCIDENT CERTIFICATE OF INSURANCE

The benefits of the Group Policy are described in this booklet. Pan-American Life Insurance Company certifies that it has issued the policy numbered as shown in Item # 2 of the Schedule to the Policyholder shown in Item # 1 of the Schedule.

This booklet is a certificate of insurance only when You are insured under the policy.



[Chairman of the Board
President and Chief Executive Officer]

All States except Texas: **IMPORTANT NOTICE: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

Texas Residents: **THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

West Virginia Residents: **Right to Return** – You have the right to return this certificate to us or our agent for cancellation within 10 days of its delivery to you. The full amount of Your premium will be refunded to you, if, after examination of this certificate you are not satisfied for any reason.

Arizona Residents: **NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL THE BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.**

Florida Residents:

Primarily the law of a state other than Florida governs the benefits of the policy providing your coverage

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OCCUPATIONAL ACCIDENT BENEFITS ONLY

SCHEDULE

This Schedule is a very brief summary of the benefits.

Please read the entire Certificate for a more complete description of the benefits outlined in this Schedule.

- Item 1. Policyholder: **[Professional Association of Independent Contractors
12850 Spurling Road, Suite 170
Dallas, TX 75230]**
- Item 2. Policy Number: **[12345]** Item 2A: Participant/Sponsor Number: **[12345]**
- Item 3. Participant Sponsor: **[ABC Company]**
- Item 4. Participant/Sponsor's Effective Date: **[mm/dd/yyyy] 12:01AM**, Standard Time at the address of the Participant/Sponsor. Participant/Sponsor's Expiration Date: **[mm/dd/yyyy] 12:01AM**, Standard Time at the address of the Participant/Sponsor.
- Item 5. Covered Subscriber: As named and reported on the monthly census by the Participant/Sponsor
- Item 6. Subscriber's SS #: As on file
- Item 7. Subscribers Enrollment Date: As on file
- Item 8. Eligible Classes: As shown below and defined in the Covered Activity Rider:

	<u>Covered</u>	<u>Not Covered</u>
Class 1 - Owner/Operator	<u>[X]</u>	<u>[X]</u>
Class 2 - Scheduled Co-Driver	<u>[X]</u>	<u>[X]</u>
Class 3 - Scheduled Contract Driver of Owner/Operator	<u>[X]</u>	<u>[X]</u>
Class 4 - Scheduled Laborer	<u>[X]</u>	<u>[X]</u>
Class 5 - Independent Contractor (Not otherwise classified)	<u>[X]</u>	<u>[X]</u>

- Item 9. Covered Activities - Refer to Covered Activity Rider – [Trucking Operation, Courier Operation, Limousine Operation]
- Item 10. Coverage Basis: Insurance for Subscribers is limited to Occupational-Related Injuries only.
- Item 11. Amounts of Insurance:

☐ Accidental Death & Dismemberment Benefits:

- AD&D Principal Sum: **[\$50,000, \$100,000, \$150,000, 250,000, \$300,000]**
- AD&D Maximum Any One Loss: **[\$50,000, \$100,000, \$150,000, 250,000, \$300,000]**
- AD&D Reporting Period: Claims must be reported within: **[365]** days from date of accident

Accidental Death Benefit: If Injury to the Subscriber results in death within [365] days of the date of the Accident that caused the Injury, We will pay the Principal Sum as indicated below:

Installment Payment Option for Death Benefits: Yes **[X]** No **[X]**

- ☐ Initial Death Benefit: [\$5,000, \$10,000, \$15,000, 25,000, \$30,000, \$50,000] Remaining balance is payable as a Survivor's Benefit @ [1%] per month for [100] months or until satisfaction of the Survivor's Benefit; *whichever occurs first*.
- ☐ If No is checked above, the benefit for Accidental Death benefit will be paid in one Lump Sum.

Accidental Dismemberment Benefit: If injury to the Subscriber results within [365] days of the date of the Accident that caused the Injury, in any one of the Losses specified below, We will pay the percentage of the Principal Sum shown in the following Schedule of Losses for that Loss.

Schedule of Accidental Death & Dismemberment Benefits for Loss of:	Principal Sum
Life.....	[100%]
Both Hands or Both Feet.....	[100%]
Sight of Both Eyes.....	[100%]
One Hand and One Foot.....	[100%]
One Hand and the Sight of One Eye.....	[100%]
One Foot and the Sight of One Eye.....	[100%]
Speech and Hearing in Both Ears.....	[100%]
One Hand or One Foot.....	[50%]
Speech.....	[50%]
The Sight of One Eye.....	[50%]
Hearing in One Ear.....	[25%]
Thumb and Index Finger of Same Hand	[25%]

Functional Loss of Use: If Injury to the Subscriber results within 365 days of the date of the *Accident* that caused the *Injury* in any one of the losses specified below, We will pay the percentage of the Principal Sum shown below for that Loss:

Functional Loss of Use:	Principal Sum
Use of 4 Limbs	[100%]
Use of 3 Limbs	[75%]
Use of 2 Limbs	[50%]
Use of 1 Limb	[25%]

For purposes of the AD&D benefits as scheduled above, only one benefit, the highest, will be paid if You suffer more than one loss including Life, Dismemberment or Functional Loss of Use that result from the same Accident. The Functional Loss of Use Benefit will be paid according to the Installment Payment Option listed on the Schedule if the Installment Payment Option is selected.

- ☐ **Accidental Disability Benefits:**
- Disability Waiting Period: [7, 14, 28] days
 - Retroactive Benefits: No [X] Yes [X]
 - Percent of Average Weekly Wages: [66 2/3%, 70%]
 - Maximum Weekly Benefit: [\$300, \$400, \$500, \$600, \$700]
 - Disability Reporting Period: Claims must be reported within: [90] days from date of accident

	Covered	Not Covered	Maximum Payment Period
<input type="checkbox"/> Temporary Total Disability	<u>[X]</u>	<u>[X]</u>	up to [26, 52, 104, 156] weeks
<input type="checkbox"/> Permanent Total Disability	<u>[X]</u>	<u>[X]</u>	up to Age [65, 70]

☐ **Accident Medical Expense Benefits:**

- **Maximum Medical Benefit Each Person Per Occurrence:** **[\$100,000, \$250,000, \$300,000, \$2,000,000]**
- **Medical Deductible Each Person Per Occurrence:** **[\$0.00, \$100, \$250, \$500]**
- **Medical Reporting Period:** Claims must be reported within: **[90]** days from the date of the accident
- **Medical Incurral Period:** Benefits are payable for: **[26, 52, 104, 156]** weeks from the date of the accident
- **First Expenses:** Must be incurred within: **[90]** days from the date of the accident

Item 12. Additional Conditions and Limitations:

1. Premium Payment Mode **[Daily, Weekly, Monthly, Annual, Per Trip, Other]**
2. Premium Calculation Mode **[15th of the Month, Other]**
3. Age Limit (see Uniform Provisions for more details) **[AGE 65, 70]**

Item 13. Supplemental Coverage Provided for:

	<u>Covered</u>	<u>Not Covered</u>
1. Occupational Disease	[X]	[X]
2. Cumulative Trauma	[X]	[X]
3. Sojourn/Personal Deviation	[X]	[X]
4. Hernia	[X]	[X]

Item 14. Maximum Limit Each Subscriber -- Per Occurrence

We will not pay more than **[\$100,000, \$250,000, \$300,000, \$500,000, \$1,000,000, \$2,000,000]** for all benefits combined (Accidental Death and Dismemberment, Accidental Disability and Accident Medical benefits combined) for each *Subscriber*.

Item 15. Forms, endorsements and riders attached to and made a part of this policy at issuance:
[Aggregate Limit, Trucking Operation, Non-Occupational, Pre-Existing Conditions, Casual Laborer Provision, Passenger Accident]

This Certificate is not binding upon Us until countersigned below by *Our Authorized Representative*.

Authorized Representative

Date Signed

PAN-AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

(Hereafter called *We, Us, Our or Ours*)

Italicized words in this Certificate mean those terms are defined in Section 7-Definitions.

SECTION 1 – WHEN COVERAGE STARTS

When a Participant's Coverage Commences

A Participant's coverage will begin on the Participant's Effective Date.

Eligibility and When a Subscriber's Coverage Commences

The Eligibility is identified by the Eligible Class descriptions as shown on the **Schedule** and defined in the Covered Activity Rider. Coverage under the *Certificate* begins only after a Request for Insurance Form is completed and filed with and approved by *US* within 30 days.

Subscriber Deferred Effective Date: If *You* are away from work because *You* are disabled on the date coverage would start, coverage will not start until *You* are no longer *disabled* and *you* return to active work and only after a Request for Insurance Form is filed with and approved by *Us*.

SECTION 2 – WHEN COVERAGE STOPS

When a Participant's Coverage Stops

A Participant's coverage under the *group policy* shall terminate when:

- We give advance written notice of termination of the *group policy* for any reason, or
- the *Policyholder* requests in writing for the *group policy* to be terminated, or
- the *Participant* fails to pay the required premium when due (subject to any Grace Period), or
- when the *Participant* requests to terminate its participation under the *group policy*.

When a Subscriber's Coverage Stops

You may request that *Your* coverage be terminated by completing the necessary written notice and forwarding it to the *Participant/Sponsor*. The effective date of termination will be the earliest of the following:

- the date the *Participant/Sponsor* receives a written request for termination from *You*; or
- when *You* are no longer in an Eligible class; or
- when *You* stop making payments for the coverage (subject to any Grace Period); or
- when the *group policy* terminates; or
- when the *Participant/Sponsor* stops participating in this insurance; or
- when any applicable Age Limit is attained.

SECTION 3 – BENEFIT PROVISIONS

Benefits hereunder are only payable for loss sustained by a covered *Accident*. **NO BENEFITS ARE PAYABLE IN CONJUNCTION WITH AN ILLNESS OR SICKNESS, AS DEFINED HEREIN.**

Coverage A, B, C, or D applies only when indicated on the Schedule that the particular coverage is provided.

Coverage A. ACCIDENTAL DEATH BENEFIT

If *You* suffer death within [365] days after a covered Accident, Accidental Death Benefits will be paid to *Your* eligible beneficiary(ies). The benefit payable will be in accordance with the terms, conditions, limitations and exclusions of this *Certificate* and any Maximum Benefit as shown in the **Schedule**.

Installment Payment Option

[If the Installment Payment Option is shown in the **Schedule** as YES then any death benefits will be paid in monthly installments. *Your* beneficiary may not elect payment in one sum after *Your* death.

The initial Death Benefit is shown in the **Schedule**. The remaining balance will be payable as a Survivor's Benefit in monthly installments of [1%] per month for a period of [100] months after the initial payment has been made or until the satisfaction of the Survivor's Benefit; *whichever occurs first*.

If a *Subscriber* dies within [365] days after a covered Accident and before attaining the Age Limit and is survived by an eligible beneficiary, the Survivor's Benefit will be payable. This benefit will be paid in accordance with the terms, conditions, limitations and exclusions of this *Certificate*, and subject to the following:

- If a *Subscriber* is survived by a *spouse*, the *spouse* will receive a monthly benefit until he/she dies, remarries, enters into a common-law or otherwise meretricious relationship, or until the Maximum Benefit is paid, whichever occurs first;
- If the *spouse* is no longer eligible to receive this benefit, then any eligible *Dependent Child(ren)* will receive this benefit until no longer eligible, or until the Maximum Benefit has been paid, whichever comes first. Benefits to any *Dependent Child(ren)* ceases upon the child's attainment of age [19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university];
- If there are no eligible beneficiaries, no Survivor's benefit will be paid.

If the Installment Payment Option is shown in the **Schedule** as No then any death benefits will be paid in a Lump Sum.]

Beneficiary

A person becomes a beneficiary only if *You* have named the person(s) as a beneficiary on the RFI or other approved beneficiary form. Beneficiary designations may be changed by filing out a Change of Beneficiary form. If no beneficiary is named, applicable Death benefits will be paid to *Your estate*.

Coverage B. – ACCIDENTAL DISMEMBERMENT BENEFIT

The benefits payable will be in accordance with all of the terms, conditions, limitations and exclusions of this *Certificate* including the attached **Schedule**. The loss must result directly and solely from such covered Accident and be independent of disease or bodily infirmity.

The Principal Sums for Dismemberment and/or Functional Loss of Use are shown in the **Schedule**.

The term "Dismemberment" means a complete separation of a limb from the body. "Hearing or Speech Loss" means the total and irrecoverable loss of hearing or speech. "Loss of Hand" means removal at or above the wrist joint. "Loss of Foot" means removal at or above the ankle joint. "Loss of an Eye" means the total and irrecoverable loss of sight. "Loss of Thumb and Index Finger of the Same Hand" means the actual, permanent and complete severance through or above the metacarpophalangeal joints. "Functional Loss of Use" means complete paralysis of the entire limb which cannot be recovered.

If more than one Dismemberment, Loss of Life or Functional Loss of Use results from any one accident, the benefit payable is the total percentage of the Principal Sums indicated above. However, the most we will pay for all loss resulting from one accident is 100% of the Principal Sum. The Functional Loss of Use Benefit will be paid according to the Installment Payment Option listed on the Schedule if the Installment Payment Option is selected.

Coverage C.— ACCIDENTAL DISABILITY BENEFIT

We will pay an Accidental Disability Benefit for each week of *Your* disability as stated in the **Schedule**. Payment will not be made during any *Waiting Period*, unless otherwise indicated on the **Schedule**. Once the applicable *Waiting Period* is satisfied, benefits will be payable as shown in the **Schedule**.

In order to be considered under this Benefit provision, *Disability* must (1) result from a covered *Accidental Injury*, (2) begin within the Disability Reporting Period shown in the **Schedule**, (3) require the ongoing care of a legally qualified *physician* and (4) prevent *You* from engaging in work for compensation, wage or profit.

The definition of *Total Disability* will be further limited in scope by the following modes:

- **Temporary Total Disability**, a benefit, up to the Maximum Weekly Benefit shown in the **Schedule**, will be payable for *Your* inability to perform all of the substantial and material duties of *Your* regular occupation as defined in *Your Covered Contract* for up to the Maximum Payment Period shown in the **Schedule**: or
- **Permanent Total Disability**, if *You* are still disabled after the Maximum Payment Period for Temporary Total Disability, a benefit will be payable, up to the Maximum Payment Period for *Permanent Total Disability* as shown in the **Schedule**, if

You:

- Cannot engage in any work for pay or profit, and are unable to perform all of the substantial and material duties of ANY occupational or employment which *You* might qualify for by reason of education, training or experience, and
- Are granted a Total Disability Award status and *You* start receiving disability payments by the Social Security Administration for such *Total Disability*. If *You* are ruled ineligible based on the status or *You* are ineligible for Social Security Administration disability payments for any reason, *You* will also be deemed ineligible for payments under this *Permanent Total Disability* benefit.

For Temporary Total Disability, the *Accidental* Disability Benefit will be payable for the duration of the Disability after satisfying any applicable *Waiting Period*. Any Total Disability of less than one Week, one-seventh of the Weekly Benefit will be payable per full day of Disability. For *Permanent Total Disability*, the monthly benefit will be equal to 4.3 times the Weekly benefit.

Separate periods of Disability resulting from the *same or related causes* will be considered one period of *Disability* unless separated by *Your* return to active work or until *You* can perform the daily functions of a person of like age in good health for at least six (6) consecutive months.

Separate periods of Disability resulting from *unrelated causes* will be considered one period of Disability unless separated by *Your* return to active work or until *You* can perform the daily functions of a person of like age in good health for at least one full day.

The Maximum Weekly Benefit payable will be a percentage of *Your* Average Weekly Wage. At *Our* discretion, benefits may be paid on a monthly or bi-monthly basis, instead of weekly. From time to time, *Your* status will be reviewed and may require an accounting of earnings and/or proof of continued disability. *Your* failure to furnish any such required information within 30 days of written notice may result in termination of coverage and/or benefits.

Reduction in Disability Income Benefits

The amount of Total Disability Income Benefits will be reduced by the amount of any Social Security benefits payable on account of such *disability*. This amount will include any benefits payable for dependents. Cost-of-living increases in Social Security payments effective after the correct Social Security benefit has been determined will be used to reduce *Our* Disability Income Benefit.

Coverage D.—ACCIDENT MEDICAL EXPENSE BENEFITS

If You suffer *Bodily Injury* in a **covered** *Accident* that requires medical attention, We will pay for *medically necessary* services or supplies as provided for herein. **There is no coverage under this benefit for Your sickness, illness or ordinary disease of life (by whatever named called).** However, if You develop an *illness* or *disease* that is the result of and directly related to *Bodily Injury* which first occurred from a **covered** *Accident*, benefits will be payable as provided for herein. In any case, medical benefits payable are limited to expenses *Incurred* within the time frame specified under the **Medical Incurral Period** (as shown in the **Schedule**) or until any **Maximum Benefit** (as shown in the **Schedule**) has been paid, **whichever occurs first.**

Subject to Utilization Management, payment for *medically necessary* and appropriate treatment will be made in accordance with this *Certificate*. These expenses must be *Incurred* during the **Medical Incurral Period** shown in the **Schedule** and exceed the *Accident Medical Deductible*, if any, described herein, up to any **Maximum Benefit**. This benefit is payable regardless of where the expenses are *Incurred*, whether in or out of the *hospital*, subject to Utilization Management as defined herein.

Charges: Payments for covered expenses are made based upon *usual, customary and reasonable* criteria that is procedure or service specific and calculated by geographic location. Benefits are payable only up to *usual, customary and reasonable* levels; amounts in excess of this amount will not be covered.

Accident Medical Deductible: For each *Accident*, there may be a *Deductible*, as shown in the **Schedule**.

HOSPITAL EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers Your stay in facilities including a general *hospital*, up to the stated limits shown in the **Schedule**. For stays in an *Extended Care Facility/Rehabilitation Facility*, this benefit covers the average room and board costs and miscellaneous services. The confinement must begin within 14 days of discharge from a *hospital confinement* of at least 3 days for the same or related conditions, provided a legally qualified *physician* is supervising such care and certifies in writing that the patient continues to need skilled nursing care or supportive therapeutic services as part of a regimen of medical care.

SURGICAL PROCEDURES EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers the cost of surgical procedures undergone by You as a result of a covered *Accidental Injury*, up to the amount customarily charged for the procedure in the geographic locality where it is performed.

DENTAL PROCEDURES AND ORAL SURGERY

Dental procedures are not covered, except for the prompt, necessary repair to a *sound natural tooth* which results from a **covered** *Accidental Injury*. Such *injuries* must occur while covered under this *Certificate*. Subject to the Accident Medical provisions set forth herein, **certain oral surgical procedures are covered.** Covered procedures are limited to the following:

- excision of unerupted, partly erupted or impacted teeth
- repair of a fractured or dislocated jaw
- osseous surgery
- maxillofacial surgery

ANESTHESIA EXPENSE

Subject to the Accident Medical provisions set forth herein this benefit covers the costs of a legally qualified *physician* (who is not the attending surgeon or assistant surgeon) who performed anesthetic procedures, in connection with a surgical procedure for which benefits are payable due to a **covered** *Accident*. This benefit also covers the cost of the anesthetic itself. These charges are paid on a *usual, customary and reasonable* basis.

PHYSICIAN SERVICES EXPENSE

Subject to the Accident Medical provisions set forth herein, visits by a *physician* for treatment of a covered *Accidental Injury* while *You* are a registered bed patient in a *hospital*, will be paid on a *usual, customary and reasonable* basis. *Physician* care and treatment, including consultations, will be paid on a *usual, customary and reasonable* basis.

DIAGNOSTIC PROCEDURES EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers radiological or laboratory procedures recommended by a *physician* or surgeon for diagnosis in connection with a covered *Accidental Injury*. Radiological and laboratory procedures must be rendered, where possible, at centers other than a *hospital*. Venipuncture is not covered. This *Certificate* covers up to *usual, customary and reasonable* charge for *Accidents*.

PRESCRIPTION DRUG EXPENSE

Coverage for expenses *Incurred* by *You* for *prescription drugs* shall be considered payable if necessary for the care and treatment of a covered *Accidental Injury* and only when prescribed by a *Physician* when:

- Confined as an *inpatient* in a *hospital*; or
- Administered as part of a *physician's* office visit.

Expenses *Incurred* are payable subject to the *Deductible*, if any. No *prescription drug* expense benefits shall be paid for expenses related to:

- therapeutic devices or appliances (unless *We* authorize coverage under Alternative Treatment Expense)
- any prescription which *You* are entitled to receive without charge from any municipal, state or federal program
- any prescription refilled in excess of or dispensed after one (1) year from the *Physician's* original order
- immunization agents
- *experimental* drugs

HOME HEALTH CARE EXPENSE

Subject to the Accident Medical provisions set forth herein, this benefit covers certain services or supplies furnished to *You* in *Your* home in connection with a covered *Accidental Injury*. The services and supplies must be furnished under a program approved in writing by the attending *physician*, as an alternative to continued *hospital* care, and must be provided by a certified *Home Health Care Agency* and pre-approved by *Us*.

The services and supplies to which this benefit apply are:

- Part-time or intermittent nursing care by a Registered *Nurse*, or by a Licensed Practical *Nurse* under the supervision of a Registered *Nurse* if the services of a Registered *Nurse* are not available.
- Part-time or intermittent home health aide services which consist primarily of patient care of a medical therapeutic nature by other than a Registered or Licensed Practical *Nurse*;
- Physical therapy, occupational therapy, and speech therapy provided by the Home Health Agency;
- Medical supplies, drugs and medications prescribed by a *physician*, and laboratory services by or on behalf of a *hospital*, to the extent such items would have been covered under the *Hospital* Benefit if *You* had remained in the *Hospital*;

For determining the limit of benefits with respect to services set forth in items 1, 2 and 3 above, each visit by a member of a home health care team shall be considered as one home healthcare visit and four hours of home health aide service shall be considered as one home health care visit.

No payments will be made for:

- Services or supplies of a *Home Health Care Agency* furnished to anyone eligible for *Medicare*, or
- Services or supplies not included in a home healthcare plan, or

- Services of a person who ordinarily resides in the home, or is a member of the family, or
- Transportation services, and services and supplies provided to an individual primarily to assist him/her in the activities of daily living, or
- Any period during which *You* are not under the continuing care of a *physician*, or
- Expenses for services and supplies not related to medical care or treatment.

EMERGENCY ROOM EXPENSE

Subject to the Accident Medical provision set forth herein, emergency room costs for the treatment of an *injury* arising from a covered *Accident* that requires *Emergency Care* as defined by this *Certificate*, are covered on a *usual, customary and reasonable* basis.

COVERED MEDICAL EXPENSE

Subject to the Accident Medical provisions as set forth herein, the following are Eligible Expenses under this *Certificate*:

Hospital Charges for:

- the actual Room and Board expenses *Incurred* subject to *usual, customary and reasonable* charges.
- the actual expense *Incurred* for confinement in an Intensive Care Unit, Cardiac Care Unit or Burn Unit.
- miscellaneous *Hospital* services and supplies during *hospital confinement*.

UC&R Charges *Incurred* as follows:

1. for confinement in a *Rehabilitation Facility*,
2. for confinement in a *Convalescent* or *Skilled Nursing Facility*. However, such expenses are limited as follows:
 - Charges will be considered only if confinement begins within [14] days after a *Hospital Confinement* of at [least three (3) consecutive days.]
 - The Attending *Physician* certifies that confinement is *medically necessary*. Only charges *Incurred* in connection with care related to the covered *Accidental Injury* for which a *Subscriber* was confined will be eligible.
3. Surgical Procedures, as follows:
 - For *medically necessary* Surgical Procedures.
 - When two or more Surgical Procedures occur during the same operation, the Eligible Expense for all charges are as follows:
 - Charges for multiple surgical procedures performed during the same operative session which do not require separate incisions are handled as follows: the covered eligible expense for the greater procedure will be considered in full; the covered eligible expense for the next lesser procedure will be considered at 50%; and the covered eligible expense for any additional procedures will be considered at 25%.
 - When an incidental procedure is required because of a covered *Accident* and performed through the same incision, the Eligible Expense is the *UC&R* fee for the major surgical procedure only.
 - When an assistant surgeon is required to render technical assistance at an operation, the Eligible Expense for such services shall be limited to 20% of the *UC&R* charge of the surgical procedure.
 - *UC&R* charges for the following oral surgery procedures:
 - Open or closed reduction of a fracture or dislocation of the jaw;
 - Osseous surgery;
 - Maxillofacial surgery;
 - *Accidental Injury* to a sound, natural tooth
 - *UC&R* charges for reconstructive surgery; only for the following situation:
 - The treatment within six (6) months of a covered *Accidental Bodily Injury* sustained and treated while a *Subscriber*.

UC&R Charges, as follows:

- For the services of a legally qualified *physician* for medical care and/or surgical treatment including office, home visits, *hospital inpatient* care, *hospital outpatient* visit/exams, clinic care, and surgical opinion consultations;
- of registered *nurses* (RNs) or licensed practical nurses (LPNs) for private duty nursing;
- for the treatment or services rendered by a licensed Physician or Occupational Therapist under direct supervision of a *Physician* in a home setting or at a facility or institution whose primary purpose is to provide medical care for a covered *Accidental Injury*;
- of a legally qualified *Physician* or qualified Speech Therapist under direct supervision of a *Physician* for restorative speech therapy for speech loss or impairment due to a covered *Accidental Injury*, or due to surgery performed on account of a covered *Accidental Injury* other than a functional nervous disorder;
- for professional ambulance service to the *Hospital* in an emergency situation when a *Subscriber* is subsequently admitted as an *inpatient*; and transport between medical facilities when *medically necessary*;
- for drugs requiring the written prescription of a licensed *Physician*; such drugs must be necessary for the treatment of a covered *Accidental injury*;
- for radiological services, microscopic tests and laboratory tests;
- for the processing and administration of blood components, but not for the cost of the actual blood or blood components if replaced;
- for physical and manipulative therapy when such therapy is part of a *physician*-approved *Home Health Care Plan*;
- for oxygen and other gases and their administration;
- for electrocardiogram, electroencephalograms, pneumoencephalogram, basal metabolism tests, or similar well established diagnostics generally approved by *Physicians* throughout the United States;
- for the cost and administration of an anesthetic;
- for dressings, sutures, casts, splints, trusses, crutches, braces, and other necessary medical supplies;
- for rental of a wheelchair, *hospital* bed, ventilator, or other *durable medical equipment* required for therapeutic Use, or the purchase of this equipment if economically justified, whichever is less;
- for non-dental *prostheses* and *appliances* including artificial limbs, eyes, or larynx, to replace limbs or eyes lost while covered under the *Certificate*, but not the replacement thereof unless the replacement is necessary because of physiological changes;
- for services of an ambulatory or *outpatient* surgical center;
- Charges made by a *Home Health Care Agency* for care in accordance with a *Home Health Care Plan*. Such expenses include:
 - Part-time or intermittent nursing care by a registered *nurse* (R.N.), a licensed practical *nurse* (L.P.N.), a licensed vocational *nurse* (L.V.N.), or public health *nurse* who is under the direct supervision of a registered *nurse*,
 - Home health aides, and
 - Medical supplies, drugs and medicines prescribed by a *Physician*, and *durable medical equipment* prescribed by a *Physician*.

Specifically excluded from coverage under the Home Health Care benefit are the following:

- Services and supplies not included in the *Home Health Care Plan*
- Services of a person who ordinarily resides in *Your* home, or is a *close relative* of *Yours*,
- Transportation services,
- *Custodial Care* and housekeeping.

Home Health Care Visit means a visit by a member of a Home Health Care team. Each such visit that lasts for a period of four (4) hours or less is treated as one Home Health Care Visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one Home Health Care Visit;

- for Dental Services rendered by a *Physician* for treatment of an *Injury* to a sound, natural tooth if:
 - The *injury* is caused by a covered *Accident* sustained while a *Subscriber*;
 - All treatment is rendered within six (6) months of the covered *Accident*; and
 - All treatment is rendered while a *Subscriber*;
- for hyperalimentation or Total Parenteral Nutrition (TPN) for persons recovering from or preparing for surgery;
- for the services of a qualified physiotherapist.

SECTION 4 – LIMITATIONS AND EXCLUSIONS

Limitations Applicable to all Benefits.

Coverage hereunder shall not apply to any person who is acknowledged as a statutory employee of the *Participant/Sponsor* or any *Subscriber* prior to a claim being filed under this *Certificate* or to any claim brought by employees of the *Subscriber* who are not considered to be *Independent Contractors*.

No payment of benefits will be made:

1. [for, or in connection with, an *Occupational Disease* or *Cumulative Trauma* arising out of, or in the course of, any employment for wage or profit (unless specifically stated in the **Schedule** as 'covered');]
2. [for, or in connection with, an *Illness* or an *Injury* if the Subscriber is deemed to be an employee and covered under any Worker's Compensation or similar state or federal law;]
3. [for treatment, services or supplies received in a *Hospital* owned or operated by the United States Government;]
4. [for charges which *You* are not legally required to pay or for which no charge or payment would have been required if coverage was not in force;]
5. [which are in excess of *usual, customary and reasonable* charges; or which are determined to be inappropriate or not *medically necessary*;]
6. [for, or in connection with, *custodial care*, education or training;]
7. [for, or in connection with, reconstructive surgery or treatment; except as provided for herein;]
8. [as a result of war, declared or undeclared;]
9. [for eyeglasses, contact lenses and hearing aids, and examinations for their prescriptions and fitting including charges for surgical procedures for the correction of visual refractive problems (radial keratotomy), except for the replacement of eyeglasses, contact lenses or hearing aids which are damaged in a covered Accident;]
10. [for nursing, medical or surgical care or treatment rendered by a family member, including, but not limited to, a *spouse, child*, mother, father, brother, sister, parent of *spouse*, aunt, uncle, or son-in-law/daughter-in-law;]
11. [for, or in connection with dental services or supplies, except as provided for herein;]
12. [to the extent that *You* are reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any government sponsored program, including, but not limited to, *Medicare* or Social Security;]
13. [for any loss directly resulting from the commission of or attempt to commit a felony or directly resulting from being engaged in an illegal act or occupation;]
14. [for devices, equipment and supplies that are not durable medical equipment or prostheses;]
15. [for services paid, payable or required to be provided as Basic Reparations Benefits under any No-Fault Automobile Insurance Law. An uninsured or underinsured motorist will be considered *self-insured* for bodily injury expenses. We will not be required to extend benefits which are required under any No-Fault Automobile Insurance Law;]
16. [for, or in connection with, *experimental* procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;]
17. [for *experimental drugs* or substances not approved by the Food & Drug Administration, or for drugs labeled: "*Caution: Limited by Federal Law to Investigational Use*";]
18. [for non-medical *hospital* expenses such as newspapers, guest trays, beauty shop services, cots, guest accommodations, admission kit, rental of telephones, radios, televisions or any other items solely for personal use or comfort;]
19. [for care, treatment, services, supplies, materials, and/or equipment which are not *medically necessary* or which are inappropriate for the diagnosis and related care/treatment of a covered Accidental Injury;]
20. [by any provider of medical services for the time spent traveling in the course of rendering medical care;]
21. [for the services of nutritionists, acupuncturists, massage therapists, herbalists, or other unlicensed allied health professionals;]
22. [for suicide, attempted suicide or self-inflicted *Bodily Injury* while sane or insane;]
23. [for failure to complete scheduled visits and charges for completion, copying or completion of any claim form, operative report or medical records;]
24. [for a *Bodily Injury* while a *Subscriber* is:
 - Intoxicated (A *Subscriber* will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be *under the influence* of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the *Bodily Injury* occurs); or

- *Under the influence* of any narcotic, unless such narcotic was prescribed by a Physician and taken in accordance with the prescribed dosage.]
25. [for medical care or treatment received while incarcerated in a local, state or federal facility. Benefits as shown on the **Schedule** will be terminated as of the first day of incarceration;]
 26. [for sickness, disease or bacterial infections;]
 27. [for purposely self-inflicted *Injury* or any *Injury* resulting from a provoked attack;]
 28. [for any *Bodily Injury* incurred while riding or driving in any kind of organized race for profit;]
 29. [for any *Bodily Injury* incurred while travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,
 - while being used for any test or experimental purpose; or
 - while a *Subscriber* is operating, learning to operate or serving as a member of a the crew thereof; or
 - while being operated by or for or under the direction of any military authority, other than transport type aircraft;]
 30. [when skydiving, parasailing, bungee-jumping, or any similar activity; or]
 31. [for prostatitis or hemorrhoids not directly related to an accident; or]
 32. [for any amount of a covered claim that exceeds the Combined Single Limit. The Combined Single Limit is shown in the Schedule of Benefits; or]
 33. [for "*Pre-existing Conditions*". The term "*Pre-existing Condition*" means an illness or injury for which a covered *Subscriber*:
 - Incurred charges
 - Received medical treatment
 - Consulted a *physician*, or
 - Took prescribed drugs
 within 12 months before he or she became insured under a given benefit section of this policy.]

SECTION 5 – PREMIUM PROVISIONS

1. **Premium Remittance and Due Date.** Premiums are payable to *Us* or *Our* authorized representative as shown on the **Schedule**. Premiums are fully earned on the [first] day of each month.
2. **Calculation of Premiums Due.** A monthly report is required as of the first day of each month through the entire term of this *Certificate*. The report must indicate the name, address, social security number and all other required information for each *Subscriber*. The monthly premium due is determined by applying the monthly rate in force per *Subscriber* to the total number of covered *Subscribers* shown on the monthly report.

 The premium calculation mode (as shown in the **Schedule**) determines the method of use to determine the premiums charged. If indicated as "15th of the Month" then *Subscribers* added after the 15th of the month do not pay any premium for that month. If the mode is indicated as "Pro-rata" then *Subscribers* who are added during the month pay a pro-rata premium based on the number of days covered during that month times the daily rate (daily rate equals the monthly rate divided by 30). Premiums are fully earned as of the first day of each month. There are no return premiums.
3. **Past Due Premiums.** Premiums are consider in arrears on the 2nd day of each month.
4. **Grace Period.** There is a [thirty-one (31)] day Grace Period for payment of all premiums except for the premium required to effect coverage. Coverage under the *Certificate* will terminate at the end of the Grace Period unless *We* receive written notice from the *Subscriber* to terminate it earlier. This *Certificate* shall remain in full force during the Grace Period. If the required premium is not paid and received by the end of the Grace Period, coverage will be terminated back to the last day of the month for which premium was paid. In the event premiums are not received within the grace period and coverage is terminated, any claims incurred during the Grace Period will be denied. Furthermore, claims Incurred after the termination date will not be considered for payment.
5. **Modification of Premium Rates.** Premium rates will not be increased during the initial 12 months of coverage and not more than once in any 6-month period following the initial 12-month period, except for increases in the premium amount due to a change in age or geographic location of a covered *Subscriber* or an increase in the *Policy* benefit level. *We* will notify *You* of any change at least [30] days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% or more is effective.

6. **Premium for Insurance Modifications.** Premiums shall be calculated as of the day such changes in coverage take effect.
7. **Cancellation or Termination.** We may cancel or terminate *Your* coverage under this *Certificate* with at least 60 days advance written notice delivered to *You*, or mailed to *Your* last known address. *You* may also cancel or terminate *Your* coverage at any time by providing at least 30 days advance written notice mailed to *Our* last known address. In the event of cancellation, *We* will promptly return the unearned portion of any premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
8. **Waiver of Premium When Totally Disabled.** *We* will waive premium for a *Subscriber* on the first of the month following the date *We* receive due written proof of the *Subscribers' Total Disability*. This provision is subject to all of the provisions of this *Certificate*, except as to the payment of premium. If a *Subscriber's Total Disability* ends and the *Subscriber* is still eligible for insurance under this *Certificate*, coverage will continue provided that premium is paid beginning with the first of the month following the *Subscriber's* return to active work.
9. **Premiums for Additions/Deletions.** In the event *We* do not receive the necessary written notice to delete a *Subscriber*, *We* will limit any refund of premiums to a period not to exceed [60 days] from the date *We* receive such written notice that the *Subscriber* should have been deleted. In our sole discretion, any claims incurred during the period for which premiums are refunded will not be covered under this insurance

In the event *We* do not receive the necessary written notice to add a *Subscriber*, *We* will limit the *Subscriber's Enrollment Date* to no more than [30 days] prior to the date *We* are notified in writing that the *Subscriber* should have been added; provided, *We* receive evidence that the premiums for such period were actually paid and received by *Us*. Any premiums paid for the period commencing on the date the *Subscriber* should have been added and the date *We* actually accept the *Subscriber* as a covered person under this insurance, at our sole discretion shall be refunded promptly and any claims incurred during this period will not be covered under this insurance.

SECTION 6 – CLAIMS PROVISIONS

UTILIZATION MANAGEMENT

Utilization Management is a proven strategy for containing health care costs. The goal of *utilization management* is to reduce the incidence of *medically unnecessary* and inappropriate *physician* care, surgical procedures, or *hospital* admissions through a pre-certification process.

This *Certificate* provides for the utilization of *Physicians* and health care professionals to determine the medical necessity and appropriateness of procedures and review claims submitted for reimbursement. All *Physicians* and *Hospitals* will be informed of this process as applicable. If questions arise regarding *Utilization Management* requirements, please call the utilization review provider. Questions will be answered professionally and confidentially by specially trained staff.

CLAIMS HANDLING

We will designate a Claims Administrator who shall be responsible for claims processing. Claim forms are to be submitted directly to the Claims Administrator.

Claim forms can be obtained from the Claims Administrator. If a doctor or other provider is submitting a claim where benefits have been assigned, he or she may use any standard or generally accepted claim form. The claim form must be completed and accompanied by an itemized bill that shows specific services, dates of service, and other information in detail.

If there is any question with regard to *Subscriber* eligibility, continuance of coverage, payment of a claim, or if there is a dispute with the denial of a claim or the amount paid, contact should first be made with the Claims Administrator and then with the Policyholder. *You* are allowed at least 60 days to request a review of the claim. *You* have the right to review pertinent documents affecting the acceptability of a claim and to submit comments in writing. The review of the claim is normally made within 30 days after receipt of a request for review. An additional 30 days will be allowed if special circumstances require more time. A notice in writing will be sent before the expiration of the initial 30-day period if an

extension is needed. The decision on a review will be sent in writing. It will include specific reasons for the decision and will refer to pertinent *Certificate* or legal provisions on which the decision was based.

FRAUDULENT CLAIMS

Filing a false or misleading claim for benefits is a FELONY and is punishable by a fine and/or imprisonment. *We* have the right, but not the duty, to prosecute any person or organization who *We* believe may have filed for and/or received benefits as a result of filing a false or misleading claim for benefits. *We* may also prosecute, at *Our* sole discretion, any individual who *We* believe may have aided or assisted in the filing of a false or misleading claim. If a claimant is later found to be guilty of filing a false or misleading claim, *We* shall be relieved of any unpaid benefits otherwise due under this *Certificate* and shall pursue re-payment from the *Subscriber* or to any other parties for amounts already paid as may be permissible by law.

CLAIM FORMS

Upon receipt of a notice of claim, *Our* Claims Administrator will furnish to *You* such forms as are usually furnished for filing proofs of loss. If the forms are not furnished within [fifteen (15)] working days after providing adequate notice, *You* shall be deemed to have complied with the requirement of this *Certificate* as to proof of loss upon submitting, within the time fixed in this *Certificate* for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which a claim is made. It is *your* responsibility to advise the Claims Administrator if the claim form is not received.

NOTICE OF CLAIM

Written notice of claim must be given to *Us* within [ninety (90)] days after the occurrence or commencement of any loss covered by this *Certificate* or as soon thereafter as is reasonably possible. Written notice given by or on behalf of *You* to *Our* Claims Administrator, with information sufficient to identify the claimant, shall be deemed notice to *Us*.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this *Certificate*, no misstatement made by any *Subscriber* in the application for this insurance shall be used to void this *Certificate* or to deny a claim for loss *Incurred*, as defined herein, commencing after the expiration of such two (2) year period.

TIME OF PAYMENT OF CLAIMS

All benefits payable under this *Certificate* will be payable immediately upon receipt of due written proof of such loss. Should *We* fail to pay the benefits payable under this *Certificate* upon receipt of due written proof of loss, *We* shall have 30 days thereafter within which to mail a letter or notice which states the reasons *We* may have for failing to pay the claim, either in whole or in part, and which also gives a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, *We* shall then have 30 days within which to process and either pay the claim or deny it, in whole or in part, stating the reasons *We* may have for denying such claim or any portion thereof. *We* shall pay interest as required by law on the benefits due under the terms of this *Certificate* for failure on *Our* part to comply with the requirements of this provision.

SUBROGATION

To the extent that benefits are provided or paid under the *Policy*, *We* shall be subrogated to all rights of recovery which any *Subscriber* may acquire against any other party for the recovery of the amount paid under the *Policy*, however *Our* right of subrogation is secondary to the right of the *Subscriber* to be fully compensated for his damages. The *Subscriber* agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action *We* may require to facilitate enforcement of *Our* right of subrogation. *We* agree to pay *Our* portion of the *Subscriber's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *We* recover any portion of the benefits paid under the *Policy* pursuant to *Our* right of subrogation.

RIGHT OF REIMBURSEMENT

To the extent that benefits are provided or paid under the *Policy* the *Subscriber* agrees that if a *Subscriber* fully recovers his damages from a third party, then he will reimburse *Us* the portion of the damages recovered for the expenses incurred by the *Subscriber* that were provided or paid by *Us*. *We* agree to pay *Our* portion of the *Subscriber's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *We* recover any portion of the benefits paid under the *Policy* pursuant to *Our* right of reimbursement.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the duplication or overpayment of benefits for eligible expenses *incurred*. It applies when *You* are also covered by any other *Certificate* or policies. When more than one coverage exists, one *Certificate* normally pays its benefits in full and the other *Certificate* pays a reduced benefit. *We* will always pay either benefits in full or a reduced amount which when added to the benefits payable by the other *Certificate* or policies, will not exceed 100% of **Allowable Expenses**. Only the amount paid by *Us* will be charged against *Your* maximums.

Allowable Expenses: The *usual, customary & reasonable* expenses for medical and/or dental care or treatment. Part of the expenses must be covered under at least one of the policies.

As Used in this Section 6, 'policy' or 'plan' shall mean:

- coverage under a statutory workers' compensation policy;
- this *Certificate* or the *Group Policy* to which it applies;
- any group, blanket or franchise insurance policy or contract;
- a group contractual prepayment or indemnity policy;
- a group Health Maintenance Organization (HMO) contract, whether group practice or individual practice association;
- medical benefits coverage in automobile policies, to the extent permitted by law;
- any individual medical policy or coverage.

If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

Primary Plan: When *Our* Plan is primary, *Our* benefits are determined before those of the other policy. The benefits of the other policy are not considered.

Secondary Plan: When *Our* Plan is secondary, *Our* benefits are determined after those of the other *policy*. *Our* benefits may be reduced because of the other policy's benefits.

The "order of benefit determination" rules state whether *Our* Plan is the Primary Plan or Secondary Plan as to another plan covering the *Subscriber*. When there are more than two Plans covering the person, *Our* Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan(s).

ORDER OF BENEFIT DETERMINATION"

Our Certificate will be primary in all cases except for the following:

1. when any coverage is available under the federal Social Security Act or similar law; or
2. when Medicare is primary, or
3. when the *Subscriber* qualifies for Workers' Compensation or any other similar statutory program.

Right to Receive and Release Needed Information - *We* may, at *our* sole discretion, give or receive any information that *We* need to underwrite, investigate and/or settle claims under this insurance. Any person having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions or nonmedical information about *your* family or *you* is authorized to release such information to *us* or *our* designee. This includes information related to substance use or abuse. Any medical practitioner, medical facility, pharmacy, the Medical Information Bureau (MIB), employer or insurance company that may have such information is authorized to release such information to *us* or *our* designee. *We* or *our* Claims Administrator may also release this information about *your* family or *you* to the MIB or any insurer to which *you* have applied for coverage or to anyone else it deems necessary to investigate and/or settle a claim under this insurance.

SECTION 7 -- DEFINITIONS

Accident or Accidental Injury: The term "*Accident*" or "*Accidental Injury*" means an, unforeseen event, or series of events which results in *Bodily Injury*.

This event must meet all of the following:

- it must happen while *You* are covered under this Plan, and
- the *Bodily Injury* must result directly from the covered *Accident* and must be independent of an *Occupational Disease*, ordinary disease of life or bodily infirmity.
- It must be in "*Occupational Accident*"

"*Accident*" **does not** include any of the following:

- aggression in a fight, or
- suicide or attempted suicide, or
- an *Illness or Sickness* (see Definitions), or
- [*Cumulative Trauma*, unless specifically covered by this plan, or]
- [*Occupational Disease*, unless specifically covered by this plan, or]
- [*Hernia of any type*, unless specifically stated in the **Schedule** as covered].

Accident Medical Deductible: The term "*Accident Medical Deductible*" means a specified dollar amount of covered expenses which must be *Incurred* and paid by a *Subscriber* before any other covered expenses can be considered for payment under this *Certificate*.

Ambulatory Care Facility: The term "*Ambulatory Care Facility*" means a facility equipped to handle surgical procedures that require *hospital-type* facilities, but do not require *hospital confinement*. In order to qualify, an *ambulatory care facility* must:

- be established, equipped and operated for the performance of surgical procedures by *physicians* who are part of an organized medical staff; and
- have equipment and supplies not usually available to a *physician* outside a *hospital* including operating rooms, recovery room, diagnostic facilities, emergency equipment and full-time *nurses*; and
- have a written agreement with a nearby *hospital* to accept patients who develop complications and require *hospital confinement*.

Ambulatory Surgical Center: The term "*Ambulatory Surgical Center*" means an institution or facility, either free-standing or as part of a *Hospital* with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and from which he or she is discharged within a twenty-four (24) hour period.

An office maintained by a *Physician* for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an *Ambulatory Surgical Center*.

[Average Weekly Wage: The term "*Average Weekly Wage*" means the *Subscriber's* net earnings as reported to the Internal Revenue Service on Form Schedule C for the twelve (12) calendar months immediately preceeding the date of the *Accident*, divided by 52. If the period of time worked is less than one year, we will take the average of the total consecutive weeks worked as an *Independent Contractor*. The *Average Weekly Wage* will in no event be considered to be less than [\$100, \$150, 250]. If a Schedule C is not reported to the Internal Revenue Service the *Average Weekly Wage* reverts to the Minimum Weekly Benefit of [\$100, \$150, \$250].

[A *Subscriber's* average weekly compensation shall be calculated at 75% of the Gross Settlements earned by the *Subscriber* and reported on Form 1099 for the twelve (12) calendar months immediately preceding the date of the *accident*, divided by 52 weeks. If the period of time worked is less than one full year, then the average of the total consecutive weeks worked as an *independent contractor* will be used to establish the Gross Settlement amount and then adjusted by the 75% factor for offsetting expenses and operating costs incurred by the *independent contractor*. This *average weekly*

compensation amount will then be used to calculate the benefit amount payable as defined in the **Schedule** section of this policy.]

Bodily Injury: The term "Bodily Injury" means an "Occupational Accident" resulting in physical injury to a *Subscriber* which occurs during the *Coverage Period* and while the *Subscriber* is under contract and arises solely out of and in the course of his/her occupation and duties as defined in the *Covered Contract* as an *Independent Contractor*.

Convalescent or Skilled Nursing Facility: The term "Convalescent" or "Skilled Nursing Facility" means an institution or distinct part thereof, operated pursuant to law and meets all of the following conditions:

- It is licensed to provide, and is engaged in providing on an *inpatient* basis, for persons convalescing from *injury*, nursing services rendered by a registered *nurse* (R.N.), a licensed practical *nurse* (L.P.N.), or a licensed vocational *nurse* (L.V.N.) under the direction of a registered *nurse* and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential activities or daily living; and
- Its services are provided for compensation from its patients and under the full-time supervision of a *physician* or registered *nurse*; and
- It provides 24-hours per day nursing services by licensed *nurses*, under the direction of a full-time registered *nurse*; and
- It has a Medical Director and/or has a *physician* who visits the facility and its patients on a regular basis; and
- It maintains a complete medical record on each patient, and
- It is not, other than incidentally, a place for rest, custodial or educational care, the care of mental disorders, the care and treatment of substance abuse, or a home for the aged; and
- It is approved and certified by *Medicare*.

This term shall also apply to expenses *Incurred* in an institution referring to itself as an *Extended Care Facility*, *Convalescent Care Facility*, *Nursing Home* or any such other similar nomenclature.

Convalescent Period: The term "Convalescent Period" means a period of time commencing with the date of confinement to a *Convalescent or Skilled Nursing Facility*. Such confinement must meet all of the following conditions:

- Such confinement must commence within fourteen (14) days of being discharged from a *hospital*; and
- Said *hospital confinement* must have been for a period of not less than three (3) consecutive days; and
- Both the *hospital* and *convalescent* confinements must have been for the care and treatment of the same covered injury.

A *Convalescent Period* will terminate when free of confinement in any and all institutions providing *hospital* or nursing care for a period of ninety (90) consecutive days. A new *Convalescent Period* shall not commence until the previous *Convalescent Period* has terminated.

Cosmetic Procedure: The term "Cosmetic Procedure" means a procedure performed solely for the improvement of *Your* appearance and not for the improvement or restoration of a bodily function.

Coverage Period: The term "Coverage Period" means a continuous period of time that begins on the *Subscriber's Enrollment Date* and continues until coverage terminates as per the terms and conditions of this *Certificate*. Such *benefit period* will terminate on the earliest of the following dates:

- the day any Maximum Benefit applicable to a *Subscriber* is paid; or
- the day a *Subscriber* cease to be covered under this *Certificate*.

Covered Contract: The term "Covered Contract" means a legal, written work agreement which meets state *Independent Contractor* requirements and definitions as further defined in the Covered Activity Rider.

Cumulative Trauma: The term "Cumulative Trauma" means an *injury* diagnosed by a *Physician* as occurring without *Accidental Bodily Injury* being the direct cause of loss. *Cumulative Trauma* includes *injury* caused by continual stress and strain. Such *injury* may be causally related to a persons' job. Such *injury* may be due to repetitive traumatic acts. Hernia is not considered to be Cumulative Trauma.

Custodial Care: The term "*Custodial Care*" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a *Subscriber*, whether or not totally *disabled*, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision of medication which can normally be self-administered.

Durable Medical Equipment: The term "*Durable Medical Equipment*" means equipment which is:

- able to withstand repeated use;
- primarily and customarily used to serve a medical purpose; and
- not generally useful to another individual or an otherwise healthy individual.

Examples of *Durable Medical Equipment* include, but are not limited to: wheelchairs, ventilators, *hospital* type beds, etc. Examples of equipment which do not meet the definition of *Durable Medical Equipment* include, but are not limited to: humidifiers, safety bars or other similar apparatus that assist in the activities of daily living, and exercise bikes or equipment, orthopedic shoes or lifts, saunas, spas, hot tubs, etc.

Emergency Care: The term "*Emergency Care*" means those procedures or services due to *Accidental Injury* or an *Illness* that results from a covered *Accidental Injury* that requires immediate medical attention.

Experimental: The term "*Experimental*" means services and supplies which are *experimental* or investigational in nature, meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not generally recognized as accepted medical practice and includes any such services or supplies requiring Committee approval not granted at the time of service.

Home Health Care Agency: The term "*Home Health Care Agency*" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

- it is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing and other therapeutic services; and
- it has policies established by a professional clinical group associated with the agency or organization. This group must include at least one *Physician* and at least one Registered Nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a *Physician* or Registered Nurse; and
- it maintains complete medical records; and
- it has a full-time administrator.

Home Health Care Plan: The term "*Home Health Care Plan*" means a program for care and treatment established and approved by the Attending *Physician*, which provides for coordinated care in the home which is *medically necessary*.

Hospital: The term "*Hospital*" means an accredited institution which is approved as a *Hospital* by the Joint Commission of the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria;

- It is primarily engaged in providing, for compensation from its patients and on an *inpatient* basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of *physicians*. If primarily a facility for the treatment of mental and/or psychological conditions, or chemical dependency, such facility must have a bona fide arrangement by contract or otherwise with a *Hospital* to perform such surgical procedures as may be required;
- it continuously provides twenty-four (24) hours per day nursing services by Registered Nurses under the supervision of *Physicians*; and
- it is not, other than incidentally, a place for rest, the aged, a *nursing home*, a hotel or the like.

Hospital Confinement: The term "*Hospital Confinement*" means a stay as a registered bed patient in a *hospital* for 24 hours or longer. A "registered bed patient" is one assigned to a bed in any department of a *hospital* except the *outpatient* department, and who is charged for room and board. The stay must be recommended by a *physician* for a *medically necessary* purpose. The patient cannot leave the *hospital* during the stay.

Illness or Sickness: The terms "*Illness or Sickness*" means a bodily disorder, disease, physical *Illness* or psychiatric disorder. *Illness/Sickness* also includes Pregnancy.

Incurred: The term "*Incurred*" means the date on which care, treatment, services or supplies are rendered or supplied.

Incurred Expenses: The term "*Incurred Expenses*" means the cost of services and supplies rendered or supplied. Such expenses shall be considered to have been *Incurred* at the time or date the service or supply is actually provided.

Independent Contractor: The term "*Independent Contractor*" means a *Subscriber* who meets the specific legal definitions and requirements as set forth in the applicable State law for an *Independent Contractor*. The following criteria represent the minimum requirements for an *Independent Contractor*:

1. perform work under a formal written work agreement or contract defined as a *Covered Contract*, and
2. receives compensation reported under a Form 1099 for compensation and self-employment tax purposes, and
3. have responsibility for determining the time, means and method of performing the work required under a *Covered Contract*, and
4. cannot be an employee of the *Participant/Sponsor* or any scheduled Additional Insured parties covered under this *Certificate*.

A "Covered Contract" means a contract, work agreement or lease agreement which has been submitted to and approved by Us.

Injury: See "*Accident*", "*Accidental Injury*" or "*Occupational Accident*".

Inpatient: The term "*Inpatient*" means a person who is admitted to a *Hospital* and who is confined to bed for health care.

Insurance Company: means the insurance company identified on the **Schedule** as the underwriter of this insurance.

Medically Necessary: The term "*Medically Necessary*" means those medical services, supplies or treatment authorized by a *physician* to treat *Your Accidental Injury* which are:

- consistent with the symptoms or diagnosis; and
- appropriate and accepted according to good medical practice standards; and
- consistent with the most appropriate supply or level of service which can safely be provided to the patient.

Medicare: The term "*Medicare*" means all benefits under Part A and/or Part B of Title XVIII of the Social Security Act of 1965 as may be amended from time to time.

Nurse: The term "*Nurse*" means an individual who has received specialized nursing training and is authorized to use the designation "RN" Registered *Nurse*, "LPN" Licensed Practical *Nurse* or "LVN" Licensed Vocational *Nurse*, and who is duly licensed by the state or regulatory agency responsible for issuing such license in the appropriate jurisdiction.

Occupational Accident: The term "*Occupational Accident*" means an "*Accident*" resulting in Bodily Injury sustained within the time frame indicated in the **Schedule** and which meets all of the following criteria and stipulations:

- it must happen while *You* are engaged in the duties as defined in the *Covered Contract* with the *Participant/Sponsor*, and
- engaged in a covered activity as defined herein, and
- it must happen while *You* are covered under this plan, and
- the *Bodily Injury* must result directly from the *Accident* and be independent of any *Occupational Disease*, ordinary disease of life or bodily infirmity.

"*Occupational Accident*" **does not** include any of the following:

- aggression in a fight
- a sojourn or personal deviation
- suicide or attempted suicide

- [Cumulative Trauma, unless specifically covered by this plan]
- [Occupational Disease, unless specifically covered by this plan]
- [Hernia of any type, unless specifically stated in the **Schedule** as covered.]

Occupational Disease: The term “Occupational Disease” means an *Illness* arising out of a *Subscriber's* duties under a *Covered Contract* which causes damage or harm to the physical structure of the body. *Occupational Disease* does not include ordinary *Illnesses* of life to which the general public is exposed outside of the *Subscriber's* duties defined within a *Covered Contract* or a *Illness* resulting directly from an *Accident*.

Outpatient: The term “Outpatient” means a person who is not admitted as an *Inpatient* but who receives health care, services or supplies.

Physician: The term “Physician” means a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), chiropractor (D.C.), podiatrist (D.P.M.), dentist (D.D.S. or D.M.D.), optometrist (O.D.), psychologist (Ph.D.), licensed independent clinical social worker (L.I.C.S.W.), registered *nurse* clinical specialist (R.N.C.S.), any other licensed practitioner-including *nurse* practitioners, *physician* assistants, *nurse* midwives, *nurse* anesthetist. A *Physician* must be acting within the scope of their license. This definition does not include someone who is related to a *Subscriber* by blood, marriage or adoption or who is normally a member of *Your* household.

Policy: The term “Policy”, also referred to as “Group Policy” means the contract between the *insurance company* and the *Policyholder* under which *Participants* can provide insurance benefits to *Subscribers*.

Participant or Sponsor: The term “Participant or Sponsor” means a person or organization named in **Item #3 of the Schedule** that applies for coverage under the *Group Policy*. A *Participant or Sponsor* must complete a Participation Agreement and a Participant/Sponsor Submission Form agreeing to all requirements and terms specified and approved by the *insurance company*.

Policyholder: The term “Policyholder” means the organization named in **Item #1 of the Schedule**. The *Policyholder* may request cancellation of the *Group Policy*, *negotiate terms and conditions*, *request changes in coverage or amounts of insurance* and *request termination of all Certificates*.

Policy Effective Date: The term “Policy Effective Date” means the date/time designated in writing by the *insurance company* for the *Policyholder's* insurance to begin.

Participant/Sponsor Effective Date: The term “Participant/Sponsor Effective Date” means the date/time designated in writing by the *insurance company* for the *Participant/Sponsor's* participation under the policy to begin.

Pre-admission Testing: The term “Pre-admission Testing” means the actual charges made by a *Hospital* for services rendered on an outpatient basis which are *medically necessary* prior to scheduled *inpatient* confinement at the same facility.

Pre-existing Conditions: The term “Pre-existing Conditions” means an illness or injury for which a covered *Subscriber*:

- incurred charges
- received medical treatment
- consulted a physician, or
- took prescribed drugs

within 12 months before he or she became insured under a given benefit section of this policy.

Prescription Drug: The term “Prescription Drug” means any drug, under applicable state law, that is dispensed only with a written prescription from a *physician* and has a label bearing the legend: “Caution: Federal law prohibits the dispensing without a prescription”. It is also any mixed medicine with at least one ingredient bearing the above legend.

Prosthesis (or Appliance): The term “Prosthesis” means a device to replace natural body parts or limbs; “Appliance” means a device or instrument used to assist an infirmed person in ambulating (e.g., walker, cane, crutches) or which is used to remedy a chronic condition.

Rehabilitation Facility: The term "*Rehabilitation Facility*" means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more *Hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *Hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a *Rehabilitation Facility* for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such facility by the Joint Commission on the Accreditation of Health Care Organizations or the Joint Commission for the Accreditation of Rehabilitation Facilities or similar group or organization.

Sojourn/Personal Deviation: The terms "*Sojourn or Personal Deviation*" means any personal deviation that takes away or interferes with the dispatched activities of the *Participant/Sponsor*.

Sound Natural Tooth: The term "*Sound Natural Tooth*" means a tooth that has no fillings or cavities, or the fillings or cavities do not undermine the tooth cusps; the pulpal tissues are healthy and intact; and the periodontal tissue shows little or no signs of active or chronic inflammation.

Subscriber: The term "*Subscriber*" means a person or persons who are either: a) a bona fide member of the *Sponsor* - if the *Sponsor* is an association or b) an individual *Independent Contractor* of a *Participant/Sponsor* who has applied to be a *Participant* under the *Group Policy*. To be a *Subscriber*, a person must first:

- meet the eligibility requirements for coverage, and
- be *validly enrolled*, and
- be contracted with a *Participant* covered under the *Group Policy*.

A *Subscriber's* coverage will not start until a **Request for Insurance Form** is completed and signed and is approved by Us.

Subscriber's Enrollment Date: The term "*Subscriber's Enrollment Date*" means the date that written notice is given that the *Subscriber's* insurance begins.

Usual, Customary And Reasonable Fee (UC&R): The term "*Usual, Customary and Reasonable Fee*" means the lesser of:

- the *usual* fee - the charge most frequently made for the covered services or supplies by a *Physician* or *Hospital*;
- the *customary* fee - the charge made for covered services or supplies by those of similar professional standing in the same geographic area;
- the *reasonable* fee - the charge determined by considering the complexity involved, the degree of professional skill required and other pertinent factors, if (1) and (2) above cannot be easily determined.

Valid Enrollment: The term "*Valid Enrollment*" means coverage is validly in force only if the enrollment information supplied to the *Insurance Company* or its Administrator is correct. The only way coverage can be in force is if information provided regarding the *Subscriber* is accurate, complete, legible and signed. No one is authorized to waive this requirement without prior written consent from the *Insurance Company* or its Administration.

Valid and Collectible Insurance: (Applies when *Our* coverage is subject to the Coordination Of Benefits provision) The term "*Valid and Collectible Insurance*" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by any of the following plans covering *You*:

- for individuals in a group whether on an insured, self-insured, or uninsured basis, such as group, blanket or franchise insurance, prepayment plans or any other plan arranged through any school, employer, trustees, association, union or employee benefit association, including individual policies which are not exclusively health policies; and
- provided under government programs; and
- required or provided by any federal, state or local law, except Medicaid or Medicare, and
- workers' compensation or similar statutory coverage.

Waiting Period: The term "Waiting Period" means a period of time a *Subscriber* must be continuously disabled before benefits are payable.

We, Us, Our or Ours: The terms "We", "Us", "Our", or "Ours" refer to the *insurance company* underwriting this coverage.

You, Your and Yours: The terms "You", "Your" or "Yours" refer to the *Subscriber*.

SECTION 8 – UNIFORM PROVISIONS

1. **Entire Contract.** All forms and documents related to this *Certificate* are part of the entire contract between all of the parties involved. These forms and documents include:
 - all documents requested and accepted by the *Insurance Company*,
 - all *Policyholder* Agreements,
 - all *Policyholder* applications,
 - all Participation Agreements,
 - all Enrollment Forms, and
 - this *Certificate of Insurance* including its attached endorsements, riders and amendments.
2. **(a) Request for Insurance.** We will provide each person who wishes to become a *Subscriber* with a Request for Insurance Form (also referred to as an 'enrollment form') along with any other document(s) we require to start coverage. These documents must be submitted by each person to be insured and must be accurate, complete, legible and signed. The only way coverage can be in force is if the *Subscriber* accurately includes all information asked for on the Request for Insurance Form and/or Health Statement and any other documents which are requested and approved by *Us*.

(b) Misstatement of Age. If the wrong age of an *Subscriber* is given on the *Subscriber* Enrollment Form and the coverage or premium is affected by age, the coverage and/or premium will be adjusted accordingly. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverage or amount of benefits or both shall be adjusted in accordance with the *insured's* true age. Any such misstatements of age shall neither continue nor terminate insurance otherwise validly in force.

(c) Misstatement of Eligibility. We reserve the right to refund any premiums reported and paid to *Us* on any insured person who is found to not meet the *Certificate* definitions of a *Subscriber*. The inadvertent receipt of any such premiums will not obligate *Us* to any potential claims. Upon determination of such receipt, *We* will refund those specific premiums to *You* within a reasonable amount of time.

(d) Time Limit for Reporting Changes in Covered Subscribers. The *Participant/Sponsor* must report changes in covered *Subscribers* by the end of each week on forms approved by *Us* or *our* authorized representative. *We*, at our sole discretion, may not honor any changes not reported to *Us* within 60 days of the date of such change.
3. **Actions of Law.** No legal action may be brought to recover under this *Certificate* prior to 60 days after filing proof of loss. No such action may be brought after three (3) years from the time written proof of loss is required to be given.
4. **Workers' Compensation.** This *Certificate* and the benefits provided are not in lieu of, nor shall affect any requirements for coverage under any *Workers' Compensation* law or other similar law.

If a *Subscriber* is not subject to workers' compensation laws or is not eligible for workers' compensation benefits as an Independent Contractor and if coverage for *Occupational Injuries* is extended to a *Subscriber*, benefits under this insurance will be payable for any covered Accidental Injury.
5. **Benefits and Examination Determination.** Binding decisions regarding benefits covered and payable are made by *Us*. No benefits are payable for services, supplies or treatment that are not *medically necessary* and appropriate. In the course of *Pre-certification* and/or *Utilization Management*, *We* may require that a *Subscriber* be examined by a *physician* of *Our* choosing, at *Our* expense.

If a *subscriber* refuses, the claims in question may be denied.

- 6. Certificate Changes.** This *Certificate* may be changed at any time by *Us*. It is not necessary to have the consent of the *Policyholder*, *Participants* or *Subscribers* before making such changes. *Certificate* changes are made by an amendment or rider, signed by an officer of the *Insurance Company* or their designee. No agent may change the *Certificate* in any way, shape or form.
- We are not bound by any promise or statements made by any individual or agent which is not in this *Certificate* or approved in writing by *Us*.
- 7. Physical Exam and Autopsy.** We shall have the right and opportunity to examine any *Subscriber* when and as often as We may reasonably require during the pendency of a claim hereunder. We shall have the right to access an autopsy report in case of death where it is not forbidden by law.
- 8. Inadvertent Error.** At Our sole discretion, the failure of a *Participant/Sponsor* or *Subscriber* to transmit, report, pay premium or comply with any of the provisions of this *Certificate* when such failure is due to an inadvertent error or clerical mistake, will not prejudice the insurance of a *Subscriber*.
- 9. Conformity with State Statutes.** If any provision of this *Certificate* is in conflict with the statutes of the state in which it is delivered or issued for delivery, the provision is automatically amended to meet minimum requirements of the statute.
- 10. Audit.** You agree to keep records of information needed to compute premium. You agree to let *Us* or *Our* representative examine and audit all *Your* payroll, business records, and documents including ledgers, journals, registers, vouchers, contracts, dispatch logs, tax reports, disbursement records and programs for storage or retrieving data. We have the right to conduct audits during regular business hours while this *Certificate* is in force and within three (3) years after the final settlement of all claims under this *Certificate*.
- 11. Bankruptcy or Insolvency.** Your bankruptcy or insolvency will not relieve *Us* from liability under this *Certificate*. However, *Our* liability will be the same had *Your* bankruptcy or insolvency not occurred.
- 12. Inspection.** We have the right, but not the duty, to inspect *Your* operations and work places. Such inspections are not safety inspections. They relate only to the insurability of the work places and the premiums to be charged. We may give reports to *You* on the conditions found upon inspection. We do not undertake to provide for the health or safety of *Your* employees, *Independent Contractors* or the public. We do not warrant that *Your* work places are safe or healthful or that they comply with any law, regulation, code or standard.
- 13. Age Limit.** Benefits payable under this *Certificate* shall only apply to covered *Subscribers* prior to attaining the Age Limit shown in the Schedule. If the *Subscriber* reaches the Age Limit during a coverage period, AD&D benefits shall be reduced based on the Reduction of Benefits Table outlined next in #14. **Benefits for Subscribers Over [Age 70].**
- 14. Benefits for Subscribers Over [Age 70].** Benefits provided by this *Certificate* can be extended to a *Subscriber* over the age of [70] on a "**Named**" basis only. The *Subscriber* must qualify for and be approved by the Administrator before this extension of benefits will apply. The *Subscriber* must submit a Request for Extended Benefits and supply any required underwriting information including, but not limited to, an Attending Physicians statement, if required. The Administrator will advise the *Named Subscriber* in writing of any approval or disapproval of any request for extensions of benefits.

Extended Benefits. The benefits extended to *Subscribers* over the [age of 70] shall consist of Accidental Death & Dismemberment, Accidental Disability—(limited to Temporary Total benefits for a maximum of two years) and Accident Medical benefits. **No benefits are provided for Permanent Total Disability.** Your premium when [age 70] or older is based on 100% of the coverage that would be in effect if *You* were [under age 70]. "AGE" as used above refers to *Your* age on *Your* most recent birthday, regardless of the actual time of birth.

Reduction of Benefits Table. The amount payable for any AD&D loss will be reduced when *You are* [age 70] or older. The AD&D amount payable will be reduced by the applicable percentage shown in the following table:

<u>AGE ON DATE OF ACCIDENT</u>	<u>AMOUNT OF REDUCTION</u>
[70 – 74]	[35%]
[75 – 79]	[55%]
[80 – 84]	[70%]
[85 and Older]	[85%]

15. **Assignment of Disability Benefits.** Payments for Disability may be assigned to a third party as indicated on an Assignment of Benefits Form provided by *US*. The form must be completed, signed and approved by *Us* and the third party before it will take effect. Benefits paid under this Assignment of Benefits Provision will be deducted from the total amount of benefits payable to the eligible *Subscriber*.

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STATEMENT OF VARIABLES

Purpose and Use of Forms

- Brackets around numbers or alphas in a listing and punctuation or words such as “and/or” in a listing will be included or deleted as needed in order to make the statement read correctly.
- Numeric variables within the Policy and related documents will always comply with the minimum statutory requirements of the state in which the Policy is delivered.
- All names, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.

Group Policy

POLICYHOLDER: - *Policyholder name will be included*

POLICY NUMBER: - *Policy Number will be included*

POLICY EFFECTIVE DATE: - *Policy Effective Date will be included*

ANNIVERSARY DATE: - *Anniversary Date will be included*

POLICY TERM: [Effective Date] to [Expiration Date] - *the effective date and expiration date will be included*

GRACE PERIOD: [30-31 days]

PREMIUM CHANGES: [30-60 days]

POLICY CONTESTABILITY: [1-5 years]

Officer's signature – *will be verified and included*

Group Certificate

Officer's signature – *will be verified and included*

Schedule

Policyholder – *the name of the Policyholder will be included*

Policy Number – *the Policy Number will be included*

Participant/Sponsor Number - *the Participant/Sponsor Number will be included*

Participant Sponsor - *the Participant/Sponsor name will be included*

Participant Sponsor's Effective Date - *the Participant/Sponsor Effective Date will be included*

Eligible Class – *either Covered or Not Covered will be included*

Covered Activity – *any Covered Activity will be included*

If the Accidental Death & Dismemberment Benefit is selected the following will be included and the selected amount will be included:

AD&D Principal Sum: [\$50,000, \$100,000, \$150,000, 250,000, \$300,000]

AD&D Maximum Any One Loss: [\$50,000, \$100,000, \$150,000, 250,000, \$300,000]

AD&D Reporting Period: [90-365] days from date of accident

Accidental Death Benefit: [90-365] days of the date of the Accident that caused the Injury, We will pay the Principal Sum as indicated below:

The following death benefit options will be listed and the selected death benefit option will be denoted with a check mark:

Installment Payment Option for Death Benefits: Yes [X] No [X]

- ☐ Initial Death Benefit: [\$5,000, \$10,000, \$15,000, 25,000, \$30,000, \$50,000] Remaining balance is payable as a Survivor's Benefit @ [1%-10%] per month for [50-100] months or until satisfaction of the Survivor's Benefit; *whichever occurs first*.

- ☐ If No is checked above, the benefit for Accidental Death benefit will be paid in one Lump Sum.

Accidental Dismemberment Benefit: [180-365] days

Schedule of Accidental Death & Dismemberment Benefits for Loss of:

Principal Sum

Life.....	[15-100%]
Both Hands or Both Feet.....	[15-100%]
Sight of Both Eyes.....	[15-100%]
One Hand and One Foot.....	[15-100%]
One Hand and the Sight of One Eye.....	[15-100%]
One Foot and the Sight of One Eye.....	[15-100%]
Speech and Hearing in Both Ears.....	[15-100%]
One Hand or One Foot.....	[15-100%]
Speech.....	[15-100%]
The Sight of One Eye.....	[15-100%]
Hearing in One Ear.....	[15-100%]
Thumb and Index Finger of Same Hand	[15-100%]

Functional Loss of Use:

Principal Sum

Use of 4 Limbs	[15-100%]
Use of 3 Limbs	[15-100%]
Use of 2 Limbs	[15-100%]
Use of 1 Limb	[15-100%]

☐ **Accidental Disability Benefits:**

- **Disability Waiting Period:** [7, 14, 28] days
- **Retroactive Benefits:** No [X] Yes [X]
- **Percent of Average Weekly Wages:** [66 2/3%, 70%]
- **Maximum Weekly Benefit:** [\$300, \$400, \$500, \$600, \$700]
- **Disability Reporting Period: Claims must be reported within:** [60-90] days from date of accident

Covered Not Covered Maximum Payment Period

- ☐ **Temporary Total Disability** [X] [X] up to [26, 52, 104, 156] weeks
- ☐ **Permanent Total Disability** [X] [X] up to Age [65, 70]

☐ **Accident Medical Expense Benefits:**

- **Maximum Medical Benefit Each Person Per Occurrence:** [\$100,000, \$250,000, \$300,000, \$500,000, 1,000,000, \$2,000,000]
- **Medical Deductible Each Person Per Occurrence:** [\$0.00, \$100, \$250, \$500]
- **Medical Reporting Period: Claims must be reported within:** [90-365] days from the date of the accident

- **Medical Incurral Period: Benefits are payable for:** [26, 52, 104, 156] weeks from the date of the accident
- **First Expenses: Must be incurred within:** [30-365] days from the date of the accident

Item 12. Additional Conditions and Limitations:

1. Premium Payment Mode - [Daily, Weekly, Monthly, Annual, Per Trip, Other]
2. Premium Calculation Mode - [15th of the Month, Other]
3. Age Limit (see Uniform Provisions for more details) - [AGE 65, 70]

Item 13. Supplemental Coverage Provided for:

	<u>Covered</u>	<u>Not Covered</u>
1. Occupational Disease	[X]	[X]
2. Cumulative Trauma	[X]	[X]
3. Sojourn/Personal Deviation	[X]	[X]
4. Hernia	[X]	[X]

Item 14. Maximum Limit Each Subscriber -- Per Occurrence

We will not pay more than [\$100,000, \$250,000, \$300,000, \$500,000, \$1,000,000, \$2,000,000] for all benefits combined (Accidental Death and Dismemberment, Accidental Disability and Accident Medical benefits combined) for each *Subscriber*.

Item 15. Forms, endorsements and riders attached to and made a part of this policy at issuance:
[Aggregate Limit, Trucking Operation, Non-Occupational, Pre-Existing Conditions, Casual Laborer Provision, Passenger Accident]

SECTION 3 – Benefit Provisions

Coverage A. ACCIDENTAL DEATH BENEFIT

If *You* suffer death within [90-365] days after a covered Accident, Accidental Death Benefits will be paid to *Your* eligible beneficiary(ies).

Installment Payment Option [1-10%] per month for a period of [50-100] months, [180-365] days [19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university];

Installment Payment Option

[If the Installment Payment Option is shown in the **Schedule** as YES then any death benefits will be paid in monthly installments. *Your* beneficiary may not elect payment in one sum after *Your* death.

The initial Death Benefit is shown in the **Schedule**. The remaining balance will be payable as a Survivor's Benefit in monthly installments of [1%-5%] per month for a period of [12-100] months after the initial payment has been made or until the satisfaction of the Survivor's Benefit; *whichever occurs first*.

If a *Subscriber* dies within [90-365] days after a covered Accident and before attaining the Age Limit and is survived by an eligible beneficiary, the Survivor's Benefit will be payable. This benefit will be paid in accordance with the terms, conditions, limitations and exclusions of this *Certificate*, and subject to the following:

- If a *Subscriber* is survived by a *spouse*, the *spouse* will receive a monthly benefit until he/she dies, remarries, enters into a common-law or otherwise meretricious relationship, or until the Maximum Benefit is paid, whichever occurs first;
- If the *spouse* is no longer eligible to receive this benefit, then any eligible *Dependent Child(ren)* will receive this benefit until no longer eligible, or until the Maximum Benefit has been paid, whichever comes first. Benefits to any *Dependent Child(ren)* ceases upon the child's attainment of age [19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university];
- If there are no eligible beneficiaries, no Survivor's benefit will be paid.

If the Installment Payment Option is shown in the **Schedule** as No then any death benefits will be paid in a Lump Sum.]

Coverage D.—ACCIDENT MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSE

2. for confinement in a *Convalescent* or *Skilled Nursing Facility*. However, such expenses are limited as follows:

- Charges will be considered only if confinement begins within [14-30] days after a *Hospital Confinement* of at [least three (3) consecutive days.]

SECTION 4 – LIMITATIONS AND EXCLUSIONS – the following limitations and exclusions may or may not be included at the option of the group policyholder:

[for, or in connection with, an *Occupational Disease* or *Cumulative Trauma* arising out of, or in the course of, any employment for wage or profit (unless specifically stated in the **Schedule** as 'covered');]

[for, or in connection with, an *Illness* or an *Injury* if the Subscriber is deemed to be an employee and covered under any Worker's Compensation or similar state or federal law;]

[for treatment, services or supplies received in a *Hospital* owned or operated by the United States Government;]

[for charges which *You* are not legally required to pay or for which no charge or payment would have been required if coverage was not in force;]

[which are in excess of *usual, customary and reasonable* charges; or which are determined to be inappropriate or not *medically necessary*;]

[for, or in connection with, *custodial care*, education or training;]

[for, or in connection with, reconstructive surgery or treatment; except as provided for herein;]

[as a result of war, declared or undeclared;]

[for eyeglasses, contact lenses and hearing aids, and examinations for their prescriptions and fitting including charges for surgical procedures for the correction of visual refractive problems (radial keratotomy), except for the replacement of eyeglasses, contact lenses or hearing aids which are damaged in a covered Accident;]

[for nursing, medical or surgical care or treatment rendered by a family member, including, but not limited to, a *spouse, child*, mother, father, brother, sister, parent of *spouse*, aunt, uncle, or son-in-law/daughter-in-law;]

[for, or in connection with dental services or supplies, except as provided for herein;]

[to the extent that *You* are reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any government sponsored program, including, but not limited to, *Medicare* or Social Security;]

[for any loss directly resulting from the commission of or attempt to commit a felony or directly resulting from being engaged in an illegal act or occupation;]

[for devices, equipment and supplies that are not durable medical equipment or prostheses;]

[for services paid, payable or required to be provided as Basic Reparations Benefits under any No-Fault Automobile Insurance Law. An uninsured or underinsured motorist will be considered *self-insured* for

bodily injury expenses. We will not be required to extend benefits which are required under any No-Fault Automobile Insurance Law;]

[for, or in connection with, *experimental* procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;]

[for *experimental drugs* or substances not approved by the Food & Drug Administration, or for drugs labeled: "*Caution: Limited by Federal Law to Investigational Use*";]

[for non-medical *hospital* expenses such as newspapers, guest trays, beauty shop services, cots, guest accommodations, admission kit, rental of telephones, radios, televisions or any other items solely for personal use or comfort;]

[for care, treatment, services, supplies, materials, and/or equipment which are not *medically necessary* or which are inappropriate for the diagnosis and related care/treatment of a covered *Accidental Injury*;]

[by any provider of medical services for the time spent traveling in the course of rendering medical care;]

[for the services of nutritionists, acupuncturists, massage therapists, herbalists, or other unlicensed allied health professionals;]

[for suicide, attempted suicide or self-inflicted *Bodily Injury* while sane or insane;]

[for failure to complete scheduled visits and charges for completion, copying or completion of any claim form, operative report or medical records;]

[for a *Bodily Injury* while a *Subscriber* is:

- Intoxicated (A *Subscriber* will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be *under the influence* of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the *Bodily Injury* occurs); or
- *Under the influence* of any narcotic, unless such narcotic was prescribed by a Physician and taken in accordance with the prescribed dosage.]

[for medical care or treatment received while incarcerated in a local, state or federal facility. Benefits as shown on the **Schedule** will be terminated as of the first day of incarceration;]

[for sickness, disease or bacterial infections;]

[for purposely self-inflicted *Injury* or any *Injury* resulting from a provoked attack;]

[for any *Bodily Injury* incurred while riding or driving in any kind of organized race for profit;]

[for any *Bodily Injury* incurred while travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,

- while being used for any test or experimental purpose; or
- while a *Subscriber* is operating, learning to operate or serving as a member of a the crew thereof; or
- while being operated by or for or under the direction of any military authority, other than transport type aircraft;]

[when skydiving, parasailing, bungee-jumping, or any similar activity: or]

[for prostatitis or hemorrhoids not directly related to an accident; or]

[for any amount of a covered claim that exceeds the Combined Single Limit. The Combined Single Limit is shown in the Schedule of Benefits; or]

[for "*Pre-existing Conditions*". The term "*Pre-existing Condition*" means an illness or injury for which a covered *Subscriber*:

- Incurred charges
- Received medical treatment
- Consulted a *physician*, or
- Took prescribed drugs

within 12 months before he or she became insured under a given benefit section of this policy.]

SECTION 5 – PREMIUM PROVISIONS

1. **Premium Remittance and Due Date.** [first or fifteenth] day of each month.

4. **Grace Period.** [31-45] day

5. **Modification of Premium Rates.** [30-90] days

9. **Premiums for Additions/Deletions.** [30-60 days]

SECTION 6 – CLAIM PROVISIONS

CLAIM FORMS [10-30]

NOTICE OF CLAIM [30-120]

SECTION 7 – Definitions

"Accident" **does not** include any of the following: *some or all of the following will be included at the option of the group policyholder*

- *[Cumulative Trauma, unless specifically covered by this plan, or]*
- *[Occupational Disease, unless specifically covered by this plan, or]*
- *[Hernia of any type, unless specifically stated in the **Schedule** as covered].*

Average Weekly Wage: [\$100, \$150, 250]. *[A Subscriber's average weekly compensation shall be calculated at 75% of the Gross Settlements earned by the Subscriber and reported on Form 1099 for the twelve (12) calendar months immediately preceding the date of the accident, divided by 52 weeks. If the period of time worked is less than one full year, then the average of the total consecutive weeks worked as an independent contractor will be used to establish the Gross Settlement amount and then adjusted by the 75% factor for offsetting expenses and operating costs incurred by the independent contractor. This average weekly compensation amount will then be used to calculate the benefit amount payable as defined in the **Schedule** section of this policy.] – may or may not be included at the option of the group policyholder*

"Occupational Accident" **does not** include any of the following: *some or all of the following will be included at the option of the group policyholder*

- *[Cumulative Trauma, unless specifically covered by this plan]*
- *[Occupational Disease, unless specifically covered by this plan]*
- *[Hernia of any type, unless specifically stated in the **Schedule** as covered.]*

SECTION 8 – UNIFORM PROVISIONS

13. **Age Limit.** [Age 70-75].

14. **Benefits for Subscribers Over [Age 70-75].**

<u>AGE ON DATE OF ACCIDENT</u>	<u>AMOUNT OF REDUCTION</u>
[70 – 74]	[35-85%]
[75 – 79]	[35-85%]
[80 – 84]	[35-85%]
[85 and Older]	[35-85%]

